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33rd Annual Advanced Elder Law Update Seminar

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33rd Annual Advanced Elder Law Update Seminar 2024

LIVE-ON-SITE SEMINAR
Richmond/Innsbrook
Thursday, September 12
9:00 a.m.–5:30 p.m. *(Eastern Time)*
The Place at Innsbrook
4036-C Cox Road
Glen Allen, VA 23060
(804) 346-2100

COURSE SCHEDULE

8:30	Registration
9:00	**Elder Law Updates** *Shawn Majette, Karen Dunivan Konvicka*
10:00	Break
10:15	**Synergy of Special Needs Trusts and ABLE Accounts** *Elizabeth L. Gray*
11:15	Break
11:30	**Elder Law Issues in Other Areas of the Law**
	Family Law in Elder Law *Virginia C. Haizlip*
	Tax in Elder Law – Tax Considerations for Elder Law Attorneys *Melinda Merk*
	Real Estate—Protecting the House When Applying for Medicaid *Jennifer D. Kahl*
12:30	Lunch and Visit Sponsors & Exhibitors
1:30	**Special Needs Planning – It's More Than Just a Trust** *Shannon Laymon-Pecoraro*
2:30	Break

2:45 **Transfer of Retirement Assets and Pension Income Between Spouses Within the Chains of Matrimony**
Ari N. Sommer

3:45 Break

4:00 **Ethical Issues in Elder Law**
Mark W. Dellinger

5:00 Complimentary Reception—Come join us for drinks, congeniality, and fun!

NETWORK with colleagues. Attendees from both the 33rd Annual Advanced Elder Law Update Seminar 2024 and VAELA's Fall program the following day, Friday, September 13 are invited to catch up with old friends and meet new ones at our reception from 5:00 p.m. to 6:00 p.m.

33rd Annual Advanced Elder Law Update Seminar 2024

2024 Seminar Written Materials

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By choosing Virginia CLE®, you are also supporting nonprofits that help legally underserved Virginians.

Virginia CLE is the educational division of the Virginia Law Foundation (VLF), which is an IRS 501(c)(3) nonprofit organization established in 1974. The VLF is the leading philanthropy in Virginia supporting the Rule of Law, access to justice, and law-related education. It is the largest and one of the few Virginia charities that is devoted to continuing legal education as part of its core mission.

The VLF also provides grants benefitting Virginians throughout the Commonwealth. Our grant-making capacity is substantially enhanced by the generosity of donors, where one hundred percent of unrestricted gifts are currently applied to augment grants. Additionally, the net funds collected annually from Virginia CLE seminars and publications are reinvested into our mission, and a considerable portion is applied to the VLF endowment to help support future grants.

As a result, your support of Virginia CLE is also allowing our thriving charitable work to achieve even greater success. For more information about how to support the Virginia Law Foundation, please visit www.virginialawfoundation.org

SUPREME COURT OF VIRGINIA
Office of the Executive Secretary
100 North Ninth Street • Richmond, Virginia 23219-2334
PHONE: 804.786.6455 • EMAIL: galadmin@vacourts.gov • FAX: 804.786.1301

CERTIFICATION OF ATTENDANCE

CONTINUING EDUCATION FOR GUARDIANS AD LITEM FOR INCAPACITATED PERSONS -- § 64.2-2003

CERTIFY YOUR ATTENDANCE ONLINE IN THE GUARDIAN AD LITEM INFORMATION SYSTEM:

1. Login to the **Member Portal of the Virginia State Bar's website** at https://www.vsb.org/Site/Sign_In using your email address of record and password.
2. From the Member Area home page, scroll to the **bottom of the page** and locate **Guardian Ad Litem CE Records**. Click **Go**. You will be directed to your GAL continuing education record in GALIS.
3. Using GALIS, you may also review your qualification status and continuing education history, update your guardian ad litem contact information, and add or remove the judicial circuit(s) where you will accept GAL appointments.

Attorney Name:

_____
Last **First** **Middle**

VSB #: _____

Office Phone: (_____)_____ **E-mail Address:** _____
Please note that your telephone number is made available to the public. *Note: E-mail address is not made available to the public.*

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Sponsor: Virginia CLE/VAELA

Course Title: 33rd Annual Advanced Elder Law Update Seminar 2024

Credit Hours: 6.0

This training has been approved by the Office of the Executive Secretary, Supreme Court of Virginia, for continuing education credit for qualified guardians ad litem for incapacitated persons.

CERTIFICATION

Course Date: _____

By my signature below, I certify:

☐ I attended a total of _____ (hrs./mins.) of approved GAL continuing education credit hours.

NOTE: Credit is awarded for actual time in attendance rounded to the nearest half hour.

_____ _____
Date **Signature**

ABOUT THE SPEAKERS

Mark W. Dellinger, Rhodes, Butler & Dellinger, PC/*Roanoke, Virginia*
Mark concentrates on elder law, estate and disability planning, estate and trust administration, special needs trusts, and business formation and transactions. He focuses on the following subsections of the broader category of "elder law": Medicaid, SSI, assisted living and nursing home planning, guardianships, conservatorships, and veterans planning. He also serves as Guardian ad litem for adult guardianships.

He is a member of the National Academy of Elder Law Attorneys (NAELA), including the Virginia Chapter (VANAELA), the Elder Law Section of the Virginia Bar Association and the Roanoke Valley Estate Planning Council.

Mark attended the University of Richmond for his undergraduate education and the T.C. Williams School of Law at the University of Richmond for his law degree. He is an Eagle Scout.

Mark is married to Jane, a school teacher. They have three children, Jack, Ben and Samantha.

Elizabeth L. Gray, McCandlish Lillard/*Fairfax, Virginia*
Elizabeth has been practicing law since 1996. She is a member of the bar of the Commonwealth of Virginia.

Elizabeth focuses her practice in the areas of elder law, special needs planning, estate planning, guardianships, and the administration of estates. She has developed a reputation among her peers in the legal community as the "go to" person in the areas of elder law and special needs planning.

She is a Past-President and the 2011 recipient of the "Outstanding Member" award of the Virginia chapter (VAELA) of the National Academy of Elder Law Attorneys (NAELA); a member of NAELA's invitation-only Council of Advanced Practitioners; a member of the invitation-only Special Needs Alliance; and former co-chair of three different sections of the Fairfax County Bar Association: Elder Law, Wills, Trusts & Estates, and Practice Management. Elizabeth also sits on the Board of Directors for the ARC of Northern Virginia.

Virginia C. Haizlip, McCandlish Lillard/*Fairfax, Virginia*
Virginia C. Haizlip joined the firm as a new principal in 2017. Virginia's practice focuses on divorce and separation, child custody and child support, guardianships and conservatorships, estate planning, and estate administration.

Virginia has been in the practice of law since 2005, after she graduated from The George Washington University School of Law, and initially focused her practice on family law. Virginia was drawn to the practice of family law because of its dynamic nature and the opportunity to work one-on-one with clients to solve their problems. Likewise, through her work in guardianships/conservatorships, estate planning, and estate administration, she is able to interact with people and assist them in solving their legal problems.

She enjoys working with clients from all walks of life. She has represented federal employees and their spouses, employees of international NGOs and their spouses, business owners, immigrants, and stay at home parents. In addition to working with clients as their attorney, Virginia also offers mediation services as part of her practice.

Virginia is pragmatic, solution-oriented, and loves to work with her clients to select a process and guide them to an outcome that works for them and their unique families. Virginia is experienced in a variety of complex family situations. She works with clients across a variety of processes, ranging from litigation to mediation and Collaborative Divorce. She notes, "Having experience and knowledge about many different options allows me to help clients evaluate what approach is best for them."

Virginia served as the President of the Northern Virginia Chapter of the Virginia Women Attorneys Association for 2019-2020 and is a member of the Collaborative Professionals of Northern Virginia, the Virginia Academy of Elder Law Attorneys, National Academy of Elder Law Attorneys, and the Virginia Bar Association. Virginia was named as a Rising Star by Super Lawyers for Virginia every year 2010-2019 and for the District of Columbia every year 2013-2019. She has been named to the Virginia Super Lawyers list since 2022. Virginia was named an Influential Woman in the Law in 2019 and has been designated as a Top Attorney by Arlington Magazine, Northern Virginia Magazine, and has been named to the Legal Elite by Virginia Business magazine.

Jennifer D. Kahl, The Heritage Law Group/*Gloucester, Virginia*
Jennifer D. Kahl has always professionally invested herself in aiding families through end-of-life care. As a teenager, she started out as a certified nursing assistant. She worked in various retirement homes and hospitals while she earned an associate degree from Utah State University and a bachelor's degree from Brigham Young University. Jennifer's decision to work in elder law was a natural choice after graduating from William and Mary Law School. She is now a partner at The Heritage Law Group (also known as Susan I. Jean & Associates) in York County, where she specializes in Medicaid qualification, estate planning, and estate administration. Jennifer is active in the Peninsula community as a speaker on various elder law topics, including seminars for lay-people and financial professionals. Being the mother of four very young children helps Jennifer understand some of the pressures facing multi-generational families. She aspires to raise a happy family of her own and provide support to other families with proper legal planning.

Karen Dunivan Konvicka, ThompsonMcMullan/*Richmond, Virginia*
It was at *Thompson*McMullan that Karen first learned the technical aspects of trust and estate law while developing an expertise in public entitlement programs. She is excited to be back in private practice where she can work in closer proximity to individuals, especially the elderly and those with disabilities. Whether providing estate planning and administration, special needs planning and administration, or elder law, Karen is experienced in complex family situations and will help clients navigate those dynamics.

Prior to rejoining the firm, Karen was General Counsel and Director of Client Services for Commonwealth Community Trust, a national pooled special needs trust organization that provides trust administration services for beneficiaries with disabilities. Karen routinely worked with attorneys and families to plan for the receipt of assets and the proper funding of trusts, as well as the allowable use and distribution of beneficiaries' funds. Her team assisted thousands of individuals who had special needs trust accounts to maintain their public benefits such as Medicaid and Supplemental Security Income.

Most recently, Karen was Director of Strategic Operations and Services at True Link Financial, Inc., a mission-driven organization providing financial inclusion to the vulnerable and disabled community. In this role, she continued to advise regarding the importance of receiving public benefits for those with special needs.

Karen has spoken for the Virginia Continuing Legal Education Foundation, National Academy of Elder Law Attorneys (NAELA), several NAELA state chapters, The Virginia Trial Lawyers Association, National Academy of Special Needs Planners, National Association of Estate Planning Attorneys, National Business Institute, University of Texas School of Law, Stetson University College of Law, and the National Alliance on Mental Illness. She is an active member of the Virginia State Bar, National Academy of Elder Law Attorneys, and Virginia Academy of Elder Law Attorneys, and continues to speak and provide educational presentations and articles to various organizations.

Having previously served on the boards of several non-profit organizations, Karen is currently a board member of The Agecroft Association and is the Executive Director of the Alliance of Pooled Trusts. She is a proud Georgia Bulldog, Richmond Spider, and mother of twin boys.

Shannon Laymon-Pecoraro, Parks Zeigler, PLLC/*Virginia Beach, Virginia*
Shannon Laymon-Pecoraro has been practicing for 12 years in the areas of elder law, estate and trust administration, estate planning, asset protection planning, financial planning, guardianships, and conservatorships. She is a licensed attorney in the Commonwealth of Virgina and the Commonwealth of Pennsylvania.

Ms. Laymon-Pecoraro has a passion for special needs planning, which has resulted in her becoming a go-to for personal injury attorneys who need assistance navigating public benefits or otherwise protecting a client's funds. As a result, Ms. Laymon-Pecoraro has worked on hundreds of personal injury cases, developing settlement trusts, including those with special needs trust provisions and Medicare set-asides.

Ms. Laymon-Pecoraro is certified as an Elder Law Attorney (CELA) by The National Elder Law Foundation (NELF). Approved by the American Bar Association and authorized by the Pennsylvania Supreme Court. The CELA certification recognizes that an individual possesses the expertise, knowledge, and skills in the practice of elder and special needs law meet the highest qualifications demanded by the National Elder Law Foundation. As a CELA, she has experience in assessing the care and planning needs associated with the aging process. This includes the ability to assess resources for long-term care. She assists clients with determining the best course to pay for such care and how to protect personal assets.

R. Shawn Majette/*Richmond, Virginia*
Shawn recently retired from *Thompson*McMullan, PC, where he spearheaded the firm's elder law practice, with a focus in voluntary and involuntary management of legal, medical, and financial affairs of incapacitated adults since 1997. Hospitals, nursing homes, assisted living facilities, and other corporate clients often consulted Shawn for solutions to discharge and Medicaid problems. Employing trusts, powers of attorney, advance medical directives, and guardianship proceedings to protect and preserve assets, Shawn guided clients in how to qualify for Medicaid and other entitlements and how to preserve personal injury proceeds from health care costs and third parties. Shawn founded the Virginia Bar Association Elder Law Section and for many years served as both the chairperson and chair of the legislative affairs subcommittee. He assisted in drafting several current Virginia statutes relating to guardianship, conservatorship, and behavioral health, including revisions to the law of civil commitment, emergency medical consent, guardianship, and the prevention of financial abuse of incapacitated adults under durable powers of attorney. Recognized annually since 2007 by Best Lawyers in America and by his peers as "Best Lawyer in Elder Law," most recently for 2024, he is a Virginia Leader in the Law and a fellow of the Virginia Lawyers Hall of Fame.

Melinda Merk, McCandlish Lillard/*Fairfax, Virginia*
Melinda focuses on providing holistic multi-generational income and wealth transfer tax planning advice and estate and trust services to high-net-worth individuals, families, and business owners. She brings a unique and diverse perspective from her work in private law practice, Big Four accounting firms, and private banking/trust services.

Melinda has over two decades of experience advising clients with regard to domestic and foreign trusts, family limited partnerships and LLCs, grantor retained annuity trusts, dynasty trusts and other wealth transfer strategies, asset protection planning, business succession and pre-sale planning, and charitable giving. She also advises fiduciaries and beneficiaries on probate and estate and trust administration and serves as a technical expert working closely with the firm's Litigation group on estate and trust litigation matters.

As a seasoned tax and estates and trusts attorney, Melinda enjoys working with a wide range of clients to successfully protect and preserve their wealth. She has represented business owners, real estate developers, private equity partners, physicians, executives, young couples, retirees, international/expat clients and their families.
Melinda started her career at a boutique trusts and estates firm in Montgomery County, Maryland, where she developed a strong foundation in estate planning and estate and trust administration.

After completing her LL.M. in Taxation at the Georgetown University Law Center, Melinda joined the National Tax Department (Personal Financial Services group) for a Big Four accounting firm in Washington, DC, where she consulted with clients on a nationwide and global basis as a Subject Matter Specialist in the areas of income and wealth transfer tax planning.
Melinda then returned to the practice of law as a Senior Counsel in the Private Wealth Services group at a national law firm in its Northern Virginia office, with a primary focus on pre-sale planning for business owners, income and estate tax planning for international clients, and asset protection planning.

She later joined another Big Four accounting firm as a Tax Director in the Personal Financial Services group, working closely with business owners and private equity firm partners on their individual income tax and estate planning.

Prior to returning to private practice, Melinda was a Senior Vice President and Regional Trust Advisor at a large bank's Private Wealth Management group for the Greater Washington Region, where she served as a resource to clients on trust and estate planning and handled the administration and risk management of trust accounts over $5 million.

Given her diverse background, Melinda is distinctively collaborative when working with her clients and their other advisors, and highly respected among her peers through her involvement in various professional and community organizations. She was awarded the Accredited Estate Planner® (AEP®) designation by the National Association of Estate Planners & Councils, which distinguishes designees for their dedication to being a collaborative advisor and is awarded only to estate planning professionals who meet special requirements of education, experience, knowledge, professional reputation, and character.

Melinda often views her role as a "translator" by carefully listening to her clients, analyzing their situation and helping them to understand their planning options and solutions in "plain English" big picture terms. Melinda notes, "I enjoy helping clients to navigate the process and design a customized solution that is flexible, practical and understandable."

Melinda is listed among the *Washingtonian's* and *Northern Virginia Magazine*'s Top Trusts/Estates/Tax Lawyers, as well as *Virginia Business Magazine's* "Legal Elite." She is active in the estate planning

community on a local and national level and has served on the Board of the Northern Virginia Estate Planning Council and the Washington DC Estate Planning Council. Melinda is also a member of the Wills, Trusts & Estates Legislative Committee for the Virginia Bar Association and is a frequent speaker and writer on estate and trust planning.

On a personal level, Melinda is a strong supporter of local philanthropy and the arts in Northern Virginia and is a current Board member of the Community Foundation for Northern Virginia. She is also a member of the Board of Directors for Goodwin Living Foundation, and a long-time supporter and serial adopter of Lab Rescue and other animal welfare organizations.

Melinda is originally from Pittsburgh and is an avid Steelers fan. She currently resides in Reston, Virginia.

Ari N. Sommer, Harrison & Johnston/*Winchester, Virginia*

When Ari N. Sommer started practicing law, he didn't necessarily have a clear picture of which areas he wanted to focus on. But he did have a crystal-clear view of what he wanted to accomplish as an attorney: to help people who needed help, guide people who needed guidance and solve problems for those facing life's inevitable challenges.

This recognition that the law is about people – not statutes and cases and files and abstractions – defines Ari and his practice. Primarily representing clients with elder law, asset protection, and estate planning needs, he recognizes the profound impact that sound advice - delivered with clarity and compassion – can have on their lives.

Ari also understands that serving his clients begins with listening to them and treating them with respect and empathy. He wants each client to feel comfortable sharing their concerns, discussing their circumstances, and asking every question that comes to mind. By truly listening, Ari develops tailored solutions and approaches that are a direct reflection of each client's unique needs and objectives.

Clients turn to Ari when they need assistance with elder law issues, including planning for long-term care or Medicaid pre-planning and crisis care. He complements his legal knowledge with his background in health and life insurance and annuities to help clients find optimal solutions to finance their long-term care needs. He is a published author on elder law issues and an active member of professional organizations focused on seniors' legal concerns, including serving on the board of directors of the Virginia Academy of Elder Law Attorneys.

Accredited by the Department of Veterans Affairs, Ari also serves those who served our country, working to ensure that veterans and their families get the benefits they deserve.

A 2003 graduate of Pomona College, Ari earned his law degree, cum laude, from Boston College Law School in 2009. Before he established his practice here in the Shenandoah Valley in 2013, Ari's professional and personal journey took him from law firms in Manhattan to medical and legal clinics in South Africa, where he used his talents to protect the rights of those seeking asylum and protection.

Licensed to practice in Virginia, West Virginia and New York, Ari relishes all that Winchester and the Shenandoah Valley have to offer and enjoys spending his time playing outdoors with his daughter, baking, bird watching, and finding little cafes and bakeries throughout Northern Virginia and D.C.

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Elder Law Updates

Shawn Majette and Karen Dunivan Konvicka

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2024 Virginia General Assembly
Bills of Interest to Elder Law Attorneys

August 12, 2024

R. Shawn Majette
VSB # 19372
P. O. Box 646
Reedville, Virginia 22539
shawn@majette.net

The content of this outline is derived from the Virginia Legislative Information Services (LIS) Official Summary of the 2024 Session of the Virginia General Assembly.

The content includes the official table of contents and selected bills with editorial comments by the writer. To read the language of enacted bills, the reader should click / tap the bill number and read the official text in the Acts of the 2024 Assembly. When helpful this work links directly to the official highlighted text.

No editorial content is provided for failed bills. Bills which are continued to the 2025 session are highlighted when considered important for preparation or advocacy.

The last 18 pages are bills which the estimable LIS lawyers and staff considered of special note. They are not necessarily relevant to the Virginia elder law practice.

Shawn Majette

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Contents

Amends certain provisions related to the granting of a mixed beverage performing arts facility license by the Board of Directors of the Virginia Alcoholic Beverage Control Authority to allow certain facilities in Pulaski County to be eligible for such license.
Patron - Ballard

F **HB773** **Marijuana; criminal penalties.** Modifies several criminal penalties related to marijuana, imposes limits on dissemination of criminal history record information related to certain marijuana offenses, and provides a petition process for any person who has been sentenced to jail or to the custody of the Department of Corrections for a marijuana offense to seek a resentencing hearing. The bill has a delayed effective date of July 1, 2025.
Patron - Herring

F **HB1050** **Alcoholic beverage control; confectionery mixed beverage retail license.** Creates a confectionery mixed beverage retail license that authorizes the licensee to prepare and sell on the licensed premises for on-and-off premises consumption confectionery that contains five percent or less alcohol by volume. The bill provides that any alcohol contained in such confectionery shall not be in liquid form at the time of sale, unless such confectionery is a frozen dessert, as defined in the bill. The bill also sets the state and local license fee for such confectionery license and repeals the provisions of alcoholic beverage control law that created an off-premises wine and beer confectionery license.
Patron - Batten

F **HB1117** **Alcoholic beverage control; mixed beverage performing arts facility license; Cities of Norfolk and Richmond; minimum patron capacity.** Reduces from 1,400 to 400 the minimum patron capacity a performing arts facility in the City of Norfolk or Richmond is required to have as one of the conditions for being granted a mixed beverage license by the Board of Directors of the Virginia Alcoholic Beverage Control Authority.
Patron - Carr

F **HB1118** **Alcoholic beverage control; annual mixed beverage performing arts facility licenses.** Allows the Board of Directors of the Virginia Alcoholic Beverage Control Authority to issue annual mixed beverage performing arts facility licenses to persons operating food concessions at any (i) performing arts facility located in the City of Charlottesville, provided that the performing arts facility (a) is occupied under a bona fide long-term lease or concession agreement, the original term of which was more than five years; (b) has a total capacity in excess of 550 patrons; and (c) has been rehabilitated in accordance with historic preservation standards; (ii) outdoor performing arts amphitheater, arena, or similar facility that has seating for more than 5,000 persons and is located in the City of Richmond; or (iii) outdoor performing arts amphitheater, arena, or similar facility that has seating for more than 2,500 persons and is located in the City of Charlottesville.
Patron - Carr

F **HB1298** **Retail licenses.**
Patron - Williams

F **SB168** **Alcoholic beverage control; food-to-beverage ratio.** Reduces the current 45 percent food-to-beverage ratio for certain mixed beverage licensees. The bill requires that a mixed beverage restaurant, caterer's, or limited caterer's licensee meet or exceed the following: (i) for such licensees with monthly food sales of at least $4,000 but less than $10,000, the food-to-beverage ratio shall be 35 percent and (ii) for such licensees with monthly food sales of at least $10,000, there shall be no food-to-beverage ratio requirement imposed.
Patron - Reeves

F **SB317** **Alcoholic beverage control; farm winery licenses; requirements and privileges.** Exempts from certain requirements imposed on farm winery licensees by prior legislation persons that hold a farm winery license that was granted on or before July 1, 2020, and has continuously remained valid and active subsequent to its issuance if requested by such licensee. Such requirements relate to the characteristics of and tasks to be performed on the licensed premises, license qualifications, manufacturing and sale requirements and limitations, and utilization of contract winemaking services.
Patron - Stuart

F **SB416** **Alcoholic beverage control; tied house exception.** Allows a manufacturer, bottler, broker, importer, or wholesaler to sponsor or provide support, including equipment, staff, financial, and other support, for a special event for which a nonprofit organization has been issued a banquet license and partners with a governmental entity that holds a mixed beverage caterer's license, provided that the mixed beverage caterer's license held by the governmental entity is not used in coordination with such special event.
Patron - Head

F **SB423** **Cannabis control; retail market; penalties.** Establishes a framework for the creation of a retail marijuana market in the Commonwealth, to be administered by the Virginia Cannabis Control Authority. The bill allows the Authority to begin issuing all marijuana licenses on July 1, 2025; however, the bill allows certain pharmaceutical processors to begin operations on July 1, 2024, and allows a limited number of other licensees to begin operations on January 1, 2025.
Patron - Ebbin

Aviation

Passed

P **HB446** **Abandoned or derelict aircraft.** Provides that an airport has a lien on an abandoned or derelict aircraft, defined in the bill, on its property for all fees and charges for the use of the airport by such aircraft and for all fees and charges incurred by the airport for the transportation, storage, and removal of the aircraft. The bill authorizes an airport operator or his designee to retain, trade, sell, or dispose of an abandoned or derelict aircraft on the property of such airport. The bill provides for notice requirements prior to any such transfer of ownership interest in the aircraft. This bill received Governor's recommendations.
Patron - Williams

Behavioral Health and Developmental Services

Passed

P **HB125** **Special justices and independent evaluator fees; emergency custody and voluntary and involuntary**

civil admissions. Increases the fee that a special justice receives for presiding over emergency custody and voluntary and involuntary civil admissions from $86.25 to $120 for each commitment hearing and from $43.25 to $70 for each certification hearing. The bill also increases the fee that an independent evaluator receives if required to serve as a witness or an interpreter from $75 to $120 for each commitment hearing and from $43.25 to $70 for each certification hearing. The bill contains technical amendments. This bill received Governor's recommendations.
Patron - Watts

P **HB313 Office of the State Inspector General; investigations of abuse or neglect at state psychiatric hospitals; report.** Directs the Office of the State Inspector General to (i) develop a plan to fulfill its statutory obligation to fully investigate all complaints it receives alleging abuse, neglect, or inadequate care at a state psychiatric hospital and (ii) submit such plan to the Chairmen of the House Committee on Health and Human Services and the Senate Committee on Education and Health by November 1, 2024. The bill also requires the Office to submit an annual report to the General Assembly on or before November 1 of each year regarding the number of such complaints received and the number of complaints that were fully investigated by the Office.
Patron - Hope

P **HB314 State hospitals; discharge planning; report.** Provides that (i) when an individual is to be discharged from Central State Hospital, Southwestern Virginia Mental Health Institute, or Southern Virginia Mental Health Institute in 30 days or less after admission, the appropriate community services board shall implement the discharge plan developed by the state facility and (ii) when an individual is to be discharged from any other state facility in 30 days or less after admission, or from a state hospital more than 30 days after admission, the appropriate community services board or behavioral health authority shall be responsible for the individual's discharge planning. Under current law, community services boards and behavioral health authorities provide discharge planning for all individuals discharged from state hospitals, regardless of the duration of their stay. The bill requires the Department of Behavioral Health and Developmental Services to make certain annual reports by August 1 to the Governor and the General Assembly and to provide the General Assembly with a one-time evaluation of the impacts of the changes to discharge planning implemented by the bill by November 1, 2025. The bill has a delayed effective date of January 1, 2025. This bill is identical to SB 179.
Patron - Hope

P **HB327 Commissioner of Behavioral Health and Developmental Services; inclusive housing plan; individuals with disabilities.** Directs the Commissioner of Behavioral Health and Developmental Services (the Commissioner) to work with stakeholders to develop a plan to ensure that people with disabilities across the Commonwealth, including individuals affected by the Settlement Agreement entered into on August 23, 2012, pursuant to *U.S. of America v. Commonwealth of Virginia*, have an opportunity to access affordable and inclusive housing, as defined in the bill. The bill requires the Commissioner to present the plan to the Chairmen of the House Committee on Health and Human Services and the Senate Committee on Education and Health by November 1, 2025.
Patron - Feggans

P **HB434 Department of Behavioral Health and Developmental Services; facilities licensed to provide inpatient substance use disorder treatment; valid discharge plans.** Directs the Department of Behavioral Health and Developmental Services to amend its regulations to require that any facility licensed by the Department to provide inpatient substance use disorder treatment be required to prepare and record a valid discharge plan upon the discharge or withdrawal of any individual from the facility who has received substance use disorder treatment while admitted to such facility. The bill requires such discharge plan to include the provision of funds withheld from the individual's prior payments to the facility to assist the individual in the execution of such discharge plan. The bill requires the regulations to provide that failure by a facility to prepare and record valid discharge plans may result in civil penalties, license suspension, or license revocation. This bill received Governor's recommendations.
Patron - Arnold

P **HB515 Department of Behavioral Health and Developmental Services; discharge pilot program; report.** Directs the Department of Behavioral Health and Developmental Services to develop and implement a pilot program relating to the discharge of individuals at one state hospital. The bill requires the Department to submit a report on its findings and recommendations to the Governor, the House Committee on Health and Human Services, the Senate Committee on Education and Health, and the Behavioral Health Commission no later than November 1, 2025.
Patron - Hope

P **HB806 Department of Human Resource Management; employee designation and payment policies; nursing staff at state psychiatric hospitals.** Directs the Department of Human Resource Management to amend its policies to authorize the Department of Behavioral Health and Developmental Services and state psychiatric hospitals to designate as full-time employees nursing staff and psychiatric technicians who work at least 36 hours per week to permit state hospitals to use 12-hour shifts for such staff. The bill prohibits the Department from requiring reductions in pay or other benefits for such employees based solely on the fact that the employee works 36 hours per week. The bill also directs the Department to examine whether the policy change should be extended to comparable direct care positions in other executive branch agencies to improve recruitment and retention. As introduced, this bill is a recommendation of the Joint Legislative Audit and Review Commission and the Behavioral Health Commission and is identical to SB 177.
Patron - Rasoul

P **HB823 Temporary detention order; alternative transportation.** Provides that when a magistrate is determining whether an alternative transportation provider is available for the purposes of designating a transportation provider for the transportation of a person who is the subject of a temporary detention order, an alternative transportation provider shall be deemed available if the provider states that it is available to take custody of the person from law enforcement within six hours of issuance of the temporary detention order or an order changing the transportation provider.
The bill also provides that if (i) no alternative transportation provider is available to provide transportation, willing to provide transportation, and able to provide transportation in a safe manner or (ii) the law-enforcement agency elects to provide transportation, the magistrate shall designate the primary law-enforcement agency and jurisdiction designated to execute the temporary detention order to provide transportation of the person. This bill is identical to SB 497.
Patron - Cherry

P **HB861 Weapons; possession or transportation; hospital that provides mental health services or developmental services; penalty.** Makes it a Class 1 misdemeanor

for any person to knowingly possess in or transport into the building of any hospital that provides mental health services or developmental services in the Commonwealth, including an emergency department or other facility rendering emergency medical care, any (i) firearm or other weapon designed or intended to propel a missile or projectile of any kind; (ii) knife, except a pocket knife having a folding metal blade of less than three inches; or (iii) other dangerous weapon, including explosives and stun weapons. The bill also provides that notice of such prohibitions shall be posted conspicuously at the public entrance of any hospital and no person shall be convicted of the offense if such notice is not posted, unless such person had actual notice of the prohibitions. The bill provides that any such firearm, knife, explosive, or weapon shall be subject to seizure by a law-enforcement officer and forfeited to the Commonwealth and specifies exceptions to the prohibition. This bill is identical to SB 515. This bill received Governor's recommendations.
Patron - Hernandez

The demented woman sitting in her feces until she contracts sepsis cannot be taken into custody.

P **HB888** **Civil commitments and temporary detention orders; definition of mental illness; neurocognitive disorders and neurodevelopmental disabilities; Secretary of Health and Human Resources to evaluate placements for certain individuals; report.** Specifies that for the purpose of civil commitments and temporary detention orders, behaviors and symptoms that manifest from a neurocognitive disorder or neurodevelopmental disability are excluded from the definition of mental illness and are, therefore, not a basis for placing an individual under a temporary detention order or committing an individual involuntarily to an inpatient psychiatric hospital. The bill provides that if a state facility has reason to believe that an individual's behaviors or symptoms are solely a manifestation of a neurocognitive disorder or neurodevelopmental disability, the state facility may require that a licensed psychiatrist or other licensed mental health professional reevaluate the individual's eligibility for a temporary detention order before the individual is admitted and shall promptly authorize the release of an individual held under a temporary detention order if the licensed psychiatrist or other licensed mental health professional determines the individual's behaviors or symptoms are solely a manifestation of a neurocognitive disorder or neurodevelopmental disability. The foregoing provisions of the bill do not become effective unless reenacted by the 2025 Session or the General Assembly. The bill also directs the Secretary of Health and Human Resources to convene a work group to evaluate, identify, and develop placements for individuals with neurocognitive disorders and neurodevelopmental disabilities, as well as any statutory or funding changes needed to prevent inappropriate placements for such individuals, and to report his findings and recommendations by November 1, 2024. As introduced, this bill is a recommendation of the Joint Legislative Audit and Review Commission and the Behavioral Health Commission. This bill is identical to SB 176.
Patron - Watts

P **HB1242** **Emergency custody and temporary detention orders; evaluations; presence of others.** Requires (i) the evaluator conducting the evaluation of an individual to determine whether such individual meets the criteria for temporary detention or (ii) the hospital emergency department and treating physician or other health care provider designated by the physician, when providing services to an individual who is being evaluated to determine whether the individual meets the criteria for temporary detention, to allow the individual's family member or LEGAL GUARDIAN who is present and who may pro-vide support and supportive decision making to be present with the individual unless the individual objects or the evaluator or treating physician determines that their presence would create a medical, clinical, or safety risk to the patient or health care provider or interferes with patient care. This bill is identical to SB 546.
Patron - Willett

P **HB1269** **Barrier crimes; adult substance abuse and mental health services; exception.** Permits the Department of Behavioral Health and Developmental Services, providers of substance abuse or mental health services to adults, and community services boards and behavioral health authorities to hire applicants convicted of certain barrier crimes of misdemeanor assault and battery or involving controlled substances provided that such conviction occurred more than four years prior to the application date for employment. This bill is identical to SB 626.
Patron - Price

P **SB19** **Recovery residences; death and serious injury reports.** Requires the Department of Behavioral Health and Developmental Services to promulgate regulations that require recovery residences to report to the Department any death or serious injury that occurs in the recovery residence. This bill incorporates SB 190.
Patron - Favola

P **SB34** **Temporary detention; certified evaluators; report.** Authorizes hospitals with a psychiatric emergency department located in the City of Hampton to employ certain trained individuals to perform evaluations to determine whether a person meets the criteria for temporary detention for behavioral health treatment. The bill requires participating hospitals with psychiatric emergency departments in the City of Hampton to annually report the length of time between when a person who is the subject of an emergency custody order arrives at the psychiatric emergency department of a participating hospital and when the temporary detention order evaluation is completed and (ii) the number of (a) admissions, (b) psychiatric emergency department visits, (c) temporary detention order evaluations completed, (d) temporary detention orders executed, (e) individuals under temporary detention admitted to the participating hospital, and (f) individuals transferred from the psychiatric emergency department of the participating hospital to a state facility to the Senate Committee on Education and Health, the House Committee on Health and Human Services, and the Behavioral Health Commission. The bill requires participating hospitals with psychiatric emergency departments in the City of Hampton to report monthly to the Commissioner of Behavioral Health and Developmental Services the number of (a) crisis evaluations conducted each month; (b) temporary detention orders executed as a result of such evaluations and the percentage of evaluations such temporary detention orders represent; (c) reportable events associated with such temporary detention orders and the percentage of temporary detention orders that such reportable events represent; (d) certain reportable events; and (e) other events. The bill requires the Department of Behavioral Health and Developmental Services to submit by October 1, 2026, to the Senate Committee on Education and Health and the House Committee on Health and Human Services an evaluation of the overall effectiveness of certified evaluators conducting temporary detention order evaluations pursuant to the bill. The bill has an expiration date of July 1, 2026. This bill received Governor's recommendations.
Patron - Locke

P **SB176** **Civil commitments and temporary detention orders; definition of mental illness; neurocognitive disorders and neurodevelopmental disabilities; Secretary of Health and Human Resources to evaluate placements for certain individuals; report.** Specifies that for

the purpose of civil commitments and temporary detention orders, behaviors and symptoms that manifest from a neurocognitive disorder or neurodevelopmental disability are excluded from the definition of mental illness and are, therefore, not a basis for placing an individual under a temporary detention order or committing an individual involuntarily to an inpatient psychiatric hospital. The bill provides that if a state facility has reason to believe that an individual's behaviors or symptoms are solely a manifestation of a neurocognitive disorder or neurodevelopmental disability, the state facility may require that a licensed psychiatrist or other licensed mental health professional reevaluate the individual's eligibility for a temporary detention order before the individual is admitted and shall promptly authorize the release of an individual held under a temporary detention order if the licensed psychiatrist or other licensed mental health professional determines the individual's behaviors or symptoms are solely a manifestation of a neurocognitive disorder or neurodevelopmental disability. The foregoing provisions of the bill do not become effective unless reenacted by the 2025 Session of the General Assembly. The bill also directs the Secretary of Health and Human Resources to convene a work group to evaluate, identify, and develop placements for individuals with neurocognitive disorders and neurodevelopmental disabilities, as well as any statutory or funding changes needed to prevent inappropriate placements for such individuals, and to report his findings and recommendations by November 1, 2024. As introduced, this bill is a recommendation of the Joint Legislative Audit and Review Commission and the Behavioral Health Commission. This bill is identical to HB 888.
Patron - Favola

P **SB177 Department of Human Resource Management; employee designation and payment policies; nursing staff at state psychiatric hospitals.** Directs the Department of Human Resource Management to amend its policies to authorize the Department of Behavioral Health and Developmental Services and state psychiatric hospitals to designate as full-time employees nursing staff and psychiatric technicians who work at least 36 hours per week to permit state hospitals to use 12-hour shifts for such staff. The bill prohibits the Department from requiring reductions in pay or other benefits for such employees based solely on the fact that the employee works 36 hours per week. The bill also directs the Department to examine whether the policy change should be extended to comparable direct care positions in other executive branch agencies to improve recruitment and retention. As introduced, this bill is a recommendation of the Joint Legislative Audit and Review Commission and the Behavioral Health Commission and is identical to HB 806.
Patron - Favola

P **SB178 Office of the State Inspector General; investigations of abuse or neglect at state psychiatric hospitals; report.** Directs the Office of the State Inspector General to (i) develop a plan to fulfill its statutory obligation to fully investigate all complaints it receives alleging abuse, neglect, or inadequate care at a state psychiatric hospital and (ii) submit such plan to the Chairmen of the House Committee on Health and Human Services and the Senate Committee on Education and Health by November 1, 2024. The bill also requires the Office to submit an annual report to the General Assembly on or before December 1 of each year regarding the number of such complaints received and the number of complaints that were fully investigated by the Office.
Patron - Favola

P **SB179 State hospitals; discharge planning; report.** Provides that (i) when an individual is to be discharged from Central State Hospital, Southwestern Virginia Mental Health Institute, or Southern Virginia Mental Health Institute in 30 days or less after admission, the appropriate community services board shall implement the discharge plan developed by the state facility and (ii) when an individual is to be discharged from any other state facility in 30 days or less after admission, or from a state hospital more than 30 days after admission, the appropriate community services board or behavioral health authority shall be responsible for the individual's discharge planning. Under current law, community services boards and behavioral health authorities provide discharge planning for all individuals discharged from state hospitals, regardless of the duration of their stay. The bill requires the Department of Behavioral Health and Developmental Services to make certain annual reports by August 1 to the Governor and the General Assembly and to provide the General Assembly with a one-time evaluation of the impacts of the changes to discharge planning implemented by the bill by November 1, 2025. The bill has a delayed effective date of January 1, 2025. This bill is identical to HB 314.
Patron - Favola

P **SB497 Temporary detention order; alternative transportation.** Provides that when a magistrate is determining whether an alternative transportation provider is available for the purposes of designating a transportation provider for the transportation of a person who is the subject of a temporary detention order, an alternative transportation provider shall be deemed available if the provider states that it is available to take custody of the person from law enforcement within six hours of issuance of the temporary detention order or an order changing the transportation provider. The bill also provides that if (i) no alternative transportation provider is available to provide transportation, willing to provide transportation, and able to provide transportation in a safe manner or (ii) the law-enforcement agency elects to provide transportation, the magistrate shall designate the primary law-enforcement agency and jurisdiction designated to execute the temporary detention order to provide transportation of the person. This bill is identical to HB 823.
Patron - Carroll Foy

P **SB515 Weapons; possession or transportation; hospital that provides mental health services or developmental services; penalty.** Makes it a Class 1 misdemeanor for any person to knowingly possess in or transport into the building of any hospital that provides mental health services or developmental services in the Commonwealth, including an emergency department or other facility rendering emergency medical care, any (i) firearm or other weapon designed or intended to propel a missile or projectile of any kind; (ii) knife, except a pocket knife having a folding metal blade of less than three inches; or (iii) other dangerous weapon, including explosives and stun weapons. The bill also provides that notice of such prohibitions shall be posted conspicuously at the public entrance of any hospital and no person shall be convicted of the offense if such notice is not posted, unless such person had actual notice of the prohibitions. The bill provides that any such firearm, knife, explosive, or weapon shall be subject to seizure by a law-enforcement officer and forfeited to the Commonwealth and specifies exceptions to the prohibition. This bill is identical to HB 861. This bill received Governor's recommendations.
Patron - Williams Graves

P **SB546 Emergency custody and temporary detention orders; evaluations; presence of others.** Requires (i) the evaluator conducting the evaluation of an individual to determine whether such individual meets the criteria for temporary detention or (ii) the hospital emergency department and treating physician or other health care provider designated by

the physician, when providing services to an individual who is being evaluated to determine whether the individual meets the criteria for temporary detention, to allow the individual's family member or LEGAL GUARDIAN who is present and who may pro-vide support and supportive decision making to be present with the individual unless the individual objects or the evaluator or treating physician determines that their presence would create a medical, clinical, or safety risk to the patient or health care provider or interferes with patient care. This bill is identical to HB 1242.
Patron - Bagby

P **SB569 State Board of Behavioral Health and Developmental Services; regulations; crisis receiving centers; appropriate and safe use of seclusion; work group; report.** Directs the State Board of Behavioral Health and Developmental Services to amend its regulations to ensure that its licensing and human rights regulations support high-quality crisis services, including by authorizing the appropriate and safe use of seclusion in crisis receiving centers and crisis stabilization units. The bill exempts the Board's initial adoption of such regulations from the provisions of the Administrative Process Act. The bill also directs the Department of Behavioral Health and Developmental Services to convene a work group to propose additional regulations to allow for the use of (i) evidence-based and recovery-oriented seclusion and restraint practices and (ii) alternative behavior management practices that may limit or replace the use of seclusion and restraint in hospitals, residential programs, and licensed facilities. The bill requires the Department to submit a report of its findings, recommendations, and proposed regulations to the General Assembly by November 1, 2025. This bill received Governor's recommendations.
Patron - Deeds

P **SB574 Behavioral Health Commission; behavioral health and crisis response services; civil admissions laws and processes; work group; report.** Directs the Behavioral Health Commission to convene a work group to study how to effectively align current civil admissions laws and processes with new behavioral health and crisis response services and resources in the Commonwealth. The bill directs the Behavioral Health Commission to make recommendations for any statutory, regulatory, licensing, training, and reimbursement changes related to Virginia's current civil admissions process and to report such recommendations by July 1, 2025.
Patron - Deeds

P **SB603 Department of Criminal Justice Services; priority treatment for incarcerated women who are pregnant and in need of substance abuse treatment; work group; report.** Directs the Department of Criminal Justice Services, in collaboration with the Department of Behavioral Health and Developmental Services and the Department of Health, to convene a work group of relevant stakeholders to study and make recommendations related to prioritizing treatment for incarcerated women who are pregnant and in need of substance abuse treatment. The bill requires the work group to report its findings and recommendations to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2024.
Patron - McGuire

P **SB626 Barrier crimes; adult substance abuse and mental health services; exception.** Permits the Department of Behavioral Health and Developmental Services, providers of substance abuse or mental health services to adults, and community services boards and behavioral health authorities to hire applicants convicted of certain barrier crimes of misdemeanor assault and battery or involving controlled substances provided that such conviction occurred more than four years prior to the application date for employment. This bill is identical to HB 1269.
Patron - Pillion

Failed

F **HB23 Weapons; possession or transportation; facility that provides mental health services or developmental services; penalty.** Makes it a Class 1 misdemeanor for any person to possess in or transport into any facility that provides mental health services or developmental services in the Commonwealth, including a hospital or an emergency department or other facility rendering emergency medical care, any (i) firearm or other weapon designed or intended to propel a missile or projectile of any kind; (ii) knife, except a pocket knife having a folding metal blade of less than three inches; or (iii) other dangerous weapon, including explosives and stun weapons. The bill provides that any such firearm, knife, explosive, or weapon is subject to seizure by a law-enforcement officer and specifies exceptions to the prohibition.
Patron - Laufer

F **HB50 Central State Hospital; psychiatric bed allocation.** Directs Central State Hospital to designate additional beds as forensic and psychiatric beds.
Patron - Jones

F **HB504 Department of Behavioral Health and Developmental Services; licensed professionals; licensed behavior analysts; definition.** Directs the Department of Behavioral Health and Developmental Services to amend in its regulations the definition of "licensed professional" to include licensed behavior analysts.
Patron - Cohen

F **HB608 Temporary detention; certified evaluators; report.** Authorizes hospitals with a psychiatric emergency department to employ certain trained individuals to perform evaluations to determine whether a person meets the criteria for temporary detention for behavioral health treatment. The bill defines psychiatric emergency department as an emergency department of a hospital licensed by the Department of Health that is physically attached to a hospital with adult and adolescent inpatient psychiatric beds and adult detoxification beds licensed by the Department of Behavioral Health and Developmental Services. The bill requires participating hospitals with psychiatric emergency departments to annually report the number of temporary detention order evaluations completed, the number of temporary detention orders petitioned, the number of individuals evaluated for temporary detention who were determined to not meet the criteria for temporary detention, and the number of individuals under a temporary detention order admitted to a state facility to the Chairmen of the Senate Committee on Education and Health, the House Committee on Health, Welfare and Institutions, and the Behavioral Health Commission. The bill has an expiration date of July 1, 2026.
Patron - Price

F **HB808 State psychiatric hospitals; temporary detention orders; delayed admission to determine medical needs.** Allows state psychiatric hospitals to delay admission of an individual under a temporary detention order until the state psychiatric hospital has determined that the individual does not have potentially life-threatening medical needs that require immediate evaluation and treatment that the state psychiatric hospital is incapable of providing. This bill is a recommenda-

tion of the Joint Legislative Audit and Review Commission and the Behavioral Health Commission.

Patron - Rasoul

F **HB822 Emergency custody; transportation; transfer of custody.** Provides that, in cases in which transportation of a person subject to an emergency custody order is ordered to be provided by an alternative transportation provider, the primary law-enforcement agency that executes the order may transfer custody of the person to the alternative transportation provider immediately upon execution of the order, and that the alternative transportation provider shall maintain custody of the person from the time custody is transferred to the alternative transportation provider by the primary law-enforcement agency until such time as custody of the person is transferred to the community services board or its designee that is responsible for conducting the evaluation or the temporary detention facility, as is appropriate. The bill adds employees of and persons providing services pursuant to a contract with the Department of Behavioral Health and Developmental Services to the list of individuals who may serve as alternative transportation providers for emergency custody orders. Additionally, the bill allows for the transfer of custody to the temporary detention facility if the magistrate issuing the emergency custody order determines that the person subject to the order is not at risk to seriously harm others in the near future without any additional conditions being met.

Patron - Cherry

F **HB829 Special justice fees; emergency custody and voluntary and involuntary civil admissions.** Increases the fee that a special justice receives for presiding over emergency custody and voluntary and involuntary civil admissions hearings from $86.25 to $143.75 for each commitment hearing and from $43.25 to $70 for each certification hearing.

Patron - Williams

F **HB885 Community services boards; core of services.** Adds to the list of the core services to be provided by community services boards (i) crisis services for individuals with a mental illness or substance use disorder, (ii) outpatient mental health and substance abuse services, (iii) psychiatric rehabilitation services, (iv) peer support and family support services, (v) mental health services for members of the armed forces located 50 miles or more from a military treatment facility and veterans located 40 miles or more from a Veterans Health Administration medical facility, and (vi) care coordination services. The bill removes language that conditions the duty of community services boards to provide case management services on the availability of funding. The bill further requires community services boards to provide any such services (a) to every adult who has a serious mental illness, child who has or is at risk of serious emotional disturbance, and individual who has a substance use disorder and (b) in a timely manner and at a location that is near the individual. The bill has a delayed effective date of July 1, 2026, for most provisions.

Patron - Watts

F **HB1065 Department of Behavioral Health and Developmental Services; community services boards; quarterly stakeholder meetings.** Provides that every community services board shall conduct stakeholder meetings at least four time per year to discuss challenges, identify opportunities for improvement, and collaboratively work towards effective solutions. The bill requires each community services board to submit an annual report of such meetings to the Department of Behavioral Health and Developmental Services and authorizes the Director of the Department to provide guidance and recommendations to such boards and to revise funding in response to such reports.

Patron - Hodges

F **SB149 Department of Medical Assistance Services; Department of Behavioral Health and Developmental Services; 1915(c) Home and Community Based Services Medicaid Waivers; state plan amendments; program rule modifications.** Directs the Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services to seek to modify the program rules for certain 1915(c) Home and Community Based Services Medicaid Waivers to (i) eliminate the requirement that, in order for a legally responsible individual to receive reimbursement for personal care services, no one else is available to provide services to the member; (ii) modify the program rules to allow for respite services when the legally responsible individual is the unpaid caregiver; and (iii) modify the program rules to allow a legally responsible individual or stepparent to be the employer of record. This bill was incorporated into SB 488.

Patron - Suetterlein

F **SB190 Recovery residences; certification requirements; death and serious injury reports; work group; report.** Requires the Department of Behavioral Health and Developmental Services to promulgate regulations that require recovery residences to (i) comply with uniform health and safety requirements established by the Department and published on its website and (ii) report to the Department, in the same manner as licensed facilities and programs, any death or serious injury that occurs in the recovery residence. The bill requires the Department to maintain on its website the certification standards of the credentialing entity for each recovery residence. The bill also requires the Department to convene a work group to (a) analyze and make recommendations regarding the creation of a process through which the Department can provide oversight of all recovery residences in the Commonwealth, (b) make recommendations to ensure transparency with the public and residents or potential residents of recovery residences regarding the certification of each recovery residence, and (c) report its findings and recommendations to the General Assembly by November 1, 2024.

Patron - Subramanyam

F **SB653 State psychiatric hospitals; temporary detention orders; delayed admission to determine medical needs.** Allows state psychiatric hospitals to delay admission of an individual under a temporary detention order until the state psychiatric hospital has determined that the individual does not have potentially life-threatening medical needs that require immediate evaluation and treatment that the state psychiatric hospital is incapable of providing. This bill is a recommendation of the Joint Legislative Audit and Review Commission and the Behavioral Health Commission.

Patron - Durant

Carried Over

C **SB590 Community services boards; core of services.** Adds to the list of the core services to be provided by community services boards (i) crisis services for individuals with a mental illness or substance use disorder, (ii) outpatient mental health and substance abuse services, (iii) psychiatric rehabilitation services, (iv) peer support and family support services, (v) mental health services for members of the armed forces located 50 miles or more from a military treatment facility and veterans located 40 miles or more from a Veterans Health Administration medical facility, and (vi) care coordination services. The bill removes language that conditions the

duty of community services boards to provide case management services on the availability of funding. The bill further requires community services boards to provide any such services (a) to every adult who has a serious mental illness, child who has or is at risk of serious emotional disturbance, and individual who has a substance use disorder and (b) in a timely manner and at a location that is near the individual. The bill has a delayed effective date of July 1, 2026, for most provisions.
Patron - Deeds

Civil Remedies and Procedure

Passed

P **HB34** **Contract actions; medical debt.** Provides that in any action, including those brought by the Commonwealth, upon any contract to collect medical debt, as defined in the bill, such an action is barred if not commenced within three years from the due date applicable to the first invoice for a health care service unless the contract with a hospital or health care provider is for a payment plan that allows for a longer period of time for the collection of debt by the hospital or health care provider. The bill specifies that such limitation shall not apply to medical debt arising from services provided by programs administered by the Department of Medical Assistance Services. This bill received Governor's recommendations.
Patron - Clark

Should reduce expenses for everyone

P **HB73** **Unlawful detainer; expungement; entering of an order without further petition or hearing.** Provides that in unlawful detainer actions filed in the general district court, if the 30-day period following the dismissal of such an action has passed or if a voluntary nonsuit is taken and the six-month period following such nonsuit has passed, the court shall, without further petition or hearing, enter an order requiring the expungement of such action, provided that no order of possession has been entered. The bill provides that if a judgment is entered in favor of the defendant, such defendant may petition the court for an expungement pursuant to the petition process under current law. Additionally, the bill retains the petition process existing under current law for unlawful detainer actions commenced prior to July 1, 2024, for which the court still has records.
Patron - Hope

P **HB86** **Summons for unlawful detainer; hearing date; amendments to amount due; subsequent filings.** Specifies a process by which a plaintiff, plaintiff's attorney, or agent in an unlawful detainer action may amend the amount due to him in an unlawful detainer action. The bill further provides that if such an amendment is permitted the plaintiff shall not subsequently file additional warrants in debt against the defendant for additional amounts if those amounts could have been included in such amended amount. The bill provides that if the plaintiff requests all amounts due and owing as of the date of the hearing or if the court grants an amendment of the amounts requested, the plaintiff shall not subsequently file additional unlawful detainers or warrants in debt against the defendant for such additional amounts if those amounts could have been included in the amended amount.
Patron - Hope

P **HB140** **Adoption; award of damages; death by wrongful act.** Provides that, in a case for death by wrongful act, the child of a decedent who has been adopted after the death of such decedent shall be included in the class of beneficiaries entitled to an award of damages resulting from such case, provided that a court had not previously terminated the parental rights of such decedent. This bill is identical to SB 209.
Patron - Reid

P **HB156** **Exemptions from jury service upon request; age.** Increases from 70 to 73 the age at which a person is exempt from jury service upon request. This bill is identical to SB 638.
Patron - Green

P **HB171** **Signing of pleadings, motions, and other papers; electronic signatures.** Clarifies that an electronic signature or a digital image of a signature shall satisfy the requirement in current law that every pleading, motion, or other paper of a party be signed by at least one attorney of record. This bill is a recommendation of the Boyd-Graves Conference.
Patron - Keys-Gamarra

P **HB202** **Optometrists; expert witness testimony.** Allows an optometrist to testify as an expert witness in a court of law on certain matters within the scope of his practice. This bill is identical to SB 254.
Patron - Williams

P **HB264** **Legal notices and publications; online-only news publications; requirements.** Provides that, where any ordinance, resolution, notice, or advertisement is required by law to be published in a newspaper, such ordinance, resolution, notice, or advertisement instead may be published in an online-only news publication subject to certain requirements specified in the bill. The bill sets out a process by which an online-only news publication shall petition the circuit court of the appropriate jurisdiction to publish such ordinances, resolutions, notices, or advertisements and authorizes the court to grant such online-only news publication the authority to publish such ordinances, resolutions, notices, or advertisements for a period of one year. The bill also describes the process by which an online-only news publication may continue renewing such authority to publish in each successive year. This bill is identical to SB 157.
Patron - Hope

P **HB315** **Department of Medical Assistance Services; lien for claim of personal injuries.** Creates a process by which a lien in favor of the Department of Medical Assistance Services on a claim for personal injuries may be satisfied upon the request of the injured person who received medical care or services to treat such personal injury. The bill provides that the Department is required within 60 days of receipt of the request of the injured person to provide such injured person or his personal representative with an itemized statement detailing all health care expenses paid for by a program of the Department and a sum specific demand for payment in full and final resolution of the Department's lien. Such request shall not be made by the injured person or his personal representative until all claims for health care expenses to be paid for by a program of the Department for an alleged injury on which the claim is based have been submitted to and processed for potential payment by the Department. The bill provides that if the Department fails to respond to such request, the injured party or his personal representative may submit to the Department an offer of payment for a sum certain in satisfaction of the lien, including an explanation of the reasons for such offer, and the Department may then, within 30 days, accept or reject such offer. The bill also clarifies that such process is not the exclusive means by which an injured person or his personal representative may request such itemized statement of health care

expenses. Under the bill, the Department shall report on a quarterly basis those offers of the payment for a sum certain in satisfaction of liens to which it does not respond to the Senate Committee on Finance and Appropriations and the House Committee on Appropriations. This bill received Governor's recommendations.
Patron - Simon

P HB418 Civil actions filed on behalf of multiple persons; class actions. Provides that one or more members of a class may, as representative parties on behalf of all members, bring a civil action or may be proceeded against in a civil action, provided that (i) the class is so numerous that joinder of all members or proceeding with such actions on an individual basis is impracticable or contrary to judicial economy; (ii) there are questions of law or fact common to the class; (iii) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and (iv) the representative parties shall fairly and adequately protect the interests of the class. The bill further sets out the procedure to certify a class action, the duties of counsel appointed in a class action, the various orders a court may issue during the course of a class action, and the process by which a settlement, voluntary dismissal, or compromise may occur. The bill has a delayed effective date of January 1, 2025, and is identical to SB 259. This bill was vetoed by the Governor.
Patron - Simon

P HB432 Making copy of jury panel available to counsel. Increases from three to five full business days before a trial the timeframe within which the clerk or sheriff or other officer responsible for notifying jurors to appear in court for the trial of a case must make available to all counsel of record a copy of the jury panel to be used for the trial of such case.
Patron - Arnold

P HB640 Wrongful incarceration; compensation. Provides that any person who is convicted of a felony by a county or city circuit court of the Commonwealth and is wrongfully incarcerated for such felony shall receive, in addition to the compensation for wrongful incarceration specified under current law, not less than $30,000 for each year or fraction thereof (i) of imprisonment after being sentenced to death or (ii) that such person was required to register with the Sex Offender and Crimes Against Minors Registry. The bill further requires that the amount paid to the person wrongfully incarcerated shall be in the form of a lump sum; under current law, only the initial 25 percent of an award is required to be paid in lump sum form.
The bill further removes the bar against receiving compensation if such wrongfully incarcerated person received any funds pursuant to a settlement agreement with any person or entity for compensation or damages arising out of the factual situation in connection with the conviction. The bill replaces such requirement with a provision allowing for the wrongful incarceration compensation award to be offset by any such award in a civil action or settlement.
Patron - Sullivan

P HB641 Claims; David Wayne Kingrea; compensation for wrongful inclusion on sex offender registry. Grants relief in an amount to be appropriated to David Wayne Kingrea, who was wrongly convicted of taking indecent liberties with a minor and, as a result of such wrongful conviction, was required to register on the sex offender registry.
Patron - Sullivan

P HB740 Unlawful detainer; bifurcation of case; contested rent and damages. Provides that, at an initial hearing on an unlawful detainer, if the defendant contests the amount of rent and damages alleged to be due and owing to the plaintiff, the court shall not bifurcate the unlawful detainer case. Under current law, at the initial hearing, upon request of the plaintiff, the court is required to bifurcate the unlawful detainer case and set a continuance date no later than 120 days from the date of the initial hearing to determine final rent and damages. This bill received Governor's recommendations.
Patron - Cousins

P HB779 Permissible venue; personal injury and wrongful death actions; appointment of administrator on behalf of estate of decedent. Provides that in a personal injury or wrongful death action in which an administrator is appointed on behalf of the estate of a decedent, permissible venue shall lie only in a county or city in which venue would have been properly laid if the person for whom such appointment is made had survived. This bill is a recommendation of the Boyd-Graves Conference and is identical to SB 138.
Patron - Callsen

P HB794 Statutory agents; service of process. Adds the Clerk of the State Corporation Commission to the definition of "statutory agent" when such Clerk is appointed for the purpose of service of process on any individual, corporation, or limited partnership. The bill further applies certain methods of service of process currently applicable to limited liability corporations to nonstock corporations and domestic stock corporations. The bill provides that domestic or foreign limited liability partnerships may be served by personal service on its registered agent as directed by applicable provisions of Title 50 (Partnerships). The bill further provides that whenever the Clerk of the State Corporation Commission is appointed as the statutory agent service shall be deemed sufficient upon the person or entity being served and shall be effective on the date when service is made on the Clerk, provided, however, that the time for such person or entity to respond to process sent by the Clerk shall run from the date when the certificate of compliance is filed. This bill is a recommendation of the Boyd-Graves Conference.
Patron - Henson

P HB901 Interlocutory ruling, order, or action; motion to reconsider. Clarifies that no litigant, after making an objection or motion known to the court, shall be required to move for reconsideration to preserve his right to appeal a ruling, order, or action of the court, even if such ruling, order, or action is without prejudice to a motion to reconsider. This bill is a recommendation of the Boyd-Graves Conference.
Patron - Srinivasan

P HB1248 Debtor interrogatories; fieri facias; against whom a summons shall be issued. Requires the clerk of the court from which a fieri facias is issued to issue a summons against any person known or reasonably suspected to be a debtor to, or bailee of, the execution debtor in order to ascertain the personal estate of a judgment debtor provided the judgment creditor or his attorney files an affidavit stating as such. Under current law, such clerk of the court shall issue a summons against any debtor to, or bailee of, the execution debtor. As introduced, this bill was a recommendation of the Boyd-Graves Conference.
Patron - Williams

P HB1335 Motor vehicle value; J.D. Power Official Used Car Guide. Adds the J.D. Power Official Used Car Guide to the list of publications from which the retail value of an automobile is admissible as evidence of fair market value of such automobile in any civil or criminal case in which the price of an automobile is in issue.
Patron - Webert

P **SB138** **Permissible venue; personal injury and wrongful death actions; appointment of administrator on behalf of estate of decedent.** Provides that in a personal injury or wrongful death action in which an administrator is appointed on behalf of the estate of a decedent, permissible venue shall lie only in a county or city in which venue would have been properly laid if the person for whom such appointment is made had survived. This bill is a recommendation of the Boyd-Graves Conference and is identical to HB 779.

Patron - Carroll Foy

P **SB157** **Legal notices and publications; online-only news publications; requirements.** Provides that, where any ordinance, resolution, notice, or advertisement is required by law to be published in a newspaper, such ordinance, resolution, notice, or advertisement instead may be published in an online-only news publication subject to certain requirements specified in the bill. The bill sets out a process by which an online-only news publication shall petition the circuit court of the appropriate jurisdiction to publish such ordinances, resolutions, notices, or advertisements and authorizes the court to grant such online-only news publication the authority to publish such ordinances, resolutions, notices, or advertisements for a period of one year. The bill also describes the process by which an online-only news publication may continue renewing such authority to publish in each successive year. This bill is identical to HB 264.

Patron - Boysko

P **SB209** **Adoption; award of damages; death by wrongful act.** Provides that, in a case for death by wrongful act, the child of a decedent who has been adopted after the death of such decedent shall be included in the class of beneficiaries entitled to an award of damages resulting from such case, provided that a court had not previously terminated the parental rights of such decedent. This bill is identical to HB 140.

Patron - Perry

P **SB214** **Service of garnishment summons upon corporation, limited liability company, etc.; garnishment designee.** Requires a summons for garnishment against a corporation, limited liability company, limited partnership, financial institution, or other entity authorized to do business in the Commonwealth to be served on the garnishment designee, as that term is defined in the bill, of such corporation, limited liability company, limited partnership, financial institution, or other entity, unless such garnishment designee is also the judgment debtor. The bill provides alternative methods of service if the judgment creditor certifies that such corporation, limited liability company, limited partnership, financial institution, or other entity has no garnishment designee, such garnishment designee cannot be found at the designated address, or such garnishment designee is also the judgment debtor. Before a judgment creditor serves the registered or statutory agent of a financial institution, such creditor shall further certify that after exercising due diligence, no managing employee, as that term is defined in the bill, could be found, that such managing employee is the judgment creditor, or that such service has been authorized or requested by such institution. The bill has a delayed effective date of January 1, 2025.

Patron - Sturtevant

P **SB254** **Optometrists; expert witness testimony.** Allows an optometrist to testify as an expert witness in a court of law on certain matters within the scope of his practice. This bill is identical to HB 202.

Patron - Surovell

P **SB256** **Motor vehicle insurance claims; bad faith.** Provides that if an insurance company licensed in the Commonwealth to write motor vehicle insurance (i) denies, refuses, fails to pay, or fails to make a timely and reasonable settlement offer to its insured under the provisions of any uninsured or underinsured motorist benefits coverage in a policy of motor vehicle insurance applicable to the insured after the insured has become legally entitled to recover or (ii) after all applicable liability policy limits and underlying uninsured and underinsured motorists benefits have been tendered or paid, rejects a reasonable settlement demand made by the insured within the policy's coverage limits for uninsured or underinsured motorist benefits or fails to respond within a reasonable time after being presented with such demand after the insured has become legally entitled to recover, and it is subsequently found by a court of proper jurisdiction that such denial, refusal, or failure to timely pay or failure to make a timely and reasonable settlement offer, rejection of a reasonable settlement demand, or failure to timely accept a reasonable settlement demand was not made in good faith, in addition to the amount due and owing by the insurance company to its insured on the judgment against the tortfeasor, the insurance company shall also be liable to the insured in an amount up to double the amount of the judgment obtained against the underinsured motorist, uninsured motorist, immune motorist, unknown owner or operator, or released defendant in the underlying personal injury or wrongful death action, not to exceed $500,000, together with reasonable attorney fees for bringing the claim, and all costs and expenses incurred by the insured to secure a judgment against the tortfeasor, and interest from 30 days after the date of such denial or failure or the date the reasonable settlement demand. Under the bill, the insured or the insured's representative may seek adjudication of a claim that the insurance company did not act in good faith as a posttrial motion before the court in which the underlying personal injury or wrongful death judgment was obtained or as a separate action against the company. If the insured or the insured's representative seeks adjudication as a separate action and the underlying judgment is appealed, any action filed under this subsection shall be stayed by the court pending final resolution of the appeal of the underlying judgment. This bill received Governor’s recommendations.

Patron - Surovell

P **SB259** **Civil actions filed on behalf of multiple persons; class actions.** Provides that one or more members of a class may, as representative parties on behalf of all members, bring a civil action or may be proceeded against in a civil action, provided that (i) the class is so numerous that joinder of all members or proceeding with such actions on an individual basis is impracticable or contrary to judicial economy; (ii) there are questions of law or fact common to the class; (iii) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and (iv) the representative parties shall fairly and adequately protect the interests of the class. The bill further sets out the procedure to certify a class action, the duties of counsel appointed in a class action, the various orders a court may issue during the course of a class action, and the process by which a settlement, voluntary dismissal, or compromise may occur. The bill has a delayed effective date of January 1, 2025, and is identical to HB 418. This bill was vetoed by the Governor.

Patron - Surovell

P **SB638** **Exemptions from jury service upon request; age.** Increases from 70 to 73 the age at which a person is exempt from jury service upon request. This bill is identical to HB 156.

Patron - Jordan

ceding fiscal year except by unanimous vote of all members elected to the governing body.
Patron - McGuire

C **SB697 Solar and energy facilities; local regulation.** Prohibits a locality from including in an ordinance (i) limits on the total amount, density, or size of any ground-mounted solar facility or energy storage facility until such time that the total area under panels within the locality exceeds four percent of the total area within the locality or (ii) any prohibitions on the use of solar panels that comply with generally accepted national environmental protection and product safety standards, provided that such installation is in compliance with any provisions of a local ordinance that establishes criteria and requirements for siting.
Patron - VanValkenburg

C **SB721 Local government actions related to comprehensive plans, local planning commissions, subdivision plats and site plans, and zoning ordinances; approval process.** Makes several changes to local government land use approval processes, including (i) prohibiting use of the comprehensive plan as the basis, in whole or in part, for the disapproval of a site plan that is otherwise in conformity with duly adopted standards, ordinances, and statutes and (ii) allowing automatic approval of certain land use applications rather than a right to petition the circuit court, as provided under current law, if a locality does not approve or disapprove the application within the required timeframe. The bill also reduces from 12 months to four months the time within which a locality must initially act upon certain proposed zoning ordinance amendments and requires a locality to act on all such proposed amendments to the zoning ordinance or map that it has previously disapproved within 45 days after an amended proposal has been resubmitted for approval.
Patron - Mulchi

Courts Not of Record

Passed

P **HB172 Family or household member; definition; penalty.** Adds to the definition of family or household member, for the purposes of definitions relating to juvenile and domestic relations district courts and multiple criminal and procedural statutes, an individual who is a legal custodian of a juvenile.
Patron - Hope

P **HB266 Custodial interrogation of a child; failure to comply with section; inadmissibility of statement.** Provides that if a law-enforcement officer knowingly fails to comply with existing law regarding parental notification and contact prior to a custodial interrogation of a child, any statements made by such child shall be inadmissible in any delinquency proceeding or criminal proceeding against such child, unless the attorney for the Commonwealth proves by a preponderance of the evidence that the statement was made knowingly, intelligently, and voluntarily.
Patron - Watts

P **HB268 Juveniles; evidence of trafficking, sexual abuse, or rape by the alleged victim prior to or during the commission of the alleged offense; treatment and rehabilitation.** Requires a juvenile and domestic relations district court, when determining whether to retain jurisdiction of a juvenile defendant during a transfer hearing, to consider any evidence that such juvenile was a victim of felonious sexual assault or trafficking by the alleged victim prior to or during the commission of the alleged offense and that such alleged offense was a direct result of the juvenile being a victim of such felonious sexual assault or trafficking. The bill also requires that a study and report prior to a transfer hearing include any relevant information supporting an allegation that such juvenile was a victim of felonious sexual assault or trafficking by the alleged victim. The bill also creates a procedure for a juvenile to present such evidence in mandatory transfer cases that under current law require the juvenile and domestic relations district court to transfer the case to the circuit court and provides that upon a finding that the alleged offense was a direct result of the juvenile being a victim of such felonious sexual assault or trafficking, the juvenile and domestic relations district court can instead conduct a transfer hearing to determine whether to keep the case in juvenile court. The bill also creates a similar procedure allowing a juvenile to present such evidence in certain cases where current law requires the juvenile and domestic relations district court to transfer the case to circuit court if the attorney for the Commonwealth gives notice of an intent to proceed with such transfer. Also, in juvenile cases that are tried in circuit court, the bill allows the court to set aside a guilty verdict and instead render the juvenile delinquent if prior to the final order or within 21 days of such order, the court receives evidence that the juvenile was a victim of such felonious sexual assault or trafficking. Lastly, the bill states that it is the intent of the General Assembly that these juveniles be viewed as victims and provided treatment and services in the juvenile system.
Patron - Watts

P **HB294 Protective order in case of family abuse; termination of temporary order of child support.** Provides that when a court includes a temporary child support order with the issuance of a protective order in the case of family abuse, such temporary child support order shall terminate when a court determines child support in a subsequent proceeding or when the protective order expires, whichever occurs first. Current law requires that such temporary child support order terminate only after a court determines child support in a subsequent proceeding. This bill is a recommendation of the Judicial Council of Virginia and the Committee on District Courts.
Patron - Ballard

P **HB431 Pro tempore judicial appointments; criminal background checks; financial disclosure.** Requires that prior to an appointment as a pro tempore judge, a person submit his fingerprints for a national and Virginia criminal history record search, submit to a search of the central registry maintained by the Department of Social Services for founded complaints of child abuse and neglect, and provide a written statement of economic interests. The bill prohibits any person with a criminal felony conviction from being appointed as a pro tempore judge.
Patron - Arnold

P **HB772 Parental admission of minors for inpatient treatment.** Clarifies that for the purposes of admission of a minor to a willing mental health facility for inpatient treatment, the finding required to be made by a qualified evaluator that the minor appears to have a mental illness serious enough to warrant inpatient treatment may include a finding of substance abuse and such inpatient treatment may be related to such mental illness, which may include substance abuse. The bill also specifies that a temporary detention order shall not be required for a minor 14 years of age or older who objects to admission to be admitted to a willing facility upon the application of a parent. As introduced, this bill was a recommendation

of the Virginia Commission on Youth. This bill is identical to SB 460.
Patron - Delaney

P HB803 Expungement of juvenile court records. Provides that if a juvenile was adjudicated delinquent of a delinquent act that would be a felony if committed by an adult, other than certain felony offenses specified in the bill committed when such juvenile was 14 years of age or older, the court records shall be destroyed when the juvenile has attained the age of 29. The bill provides that if a juvenile was adjudicated delinquent of one of the felony offenses specified in the bill committed when such juvenile was 14 years of age or older, the court records shall be retained. Under current law, the court records shall be retained in all instances when a juvenile was found guilty of a delinquent act that would be a felony if committed by an adult. The bill directs the clerk of the juvenile and domestic relations district court to expunge all records pursuant to the bill by July 1, 2027. This bill was vetoed by the Governor.
Patron - Rasoul

P HB893 Standards for attorneys appointed to represent parents or guardians; child dependency cases; compensation; multidisciplinary law offices or programs; report. Requires the Judicial Council of Virginia, in conjunction with the Virginia State Bar, beginning July 1, 2026, to adopt standards for the qualification and performance of attorneys appointed to represent a parent or guardian of a child when such child is the subject of a child dependency case, as defined in the bill. The bill also requires the Judicial Council of Virginia, beginning July 1, 2026, to maintain a list of attorneys admitted to practice law in Virginia who are qualified to be appointed to represent indigent parents involved in a child dependency case. Prior to July 1, 2026, counsel must be appointed from the list of attorneys qualified to serve as guardians ad litem. The bill provides that beginning January 1, 2025, court-appointed counsel for a parent, guardian, or other adult in a child dependency case will be compensated in an amount no greater than $330, or in a case for the termination of residual parental rights, $680.
The bill authorizes the establishment of up to two multidisciplinary law offices or programs in localities, jurisdictions, or judicial districts that affirm they have met specified criteria for the purpose of representing parents in a child dependency court proceeding or in a child protective services assessment or investigation prior to such proceeding. During any calendar year that such an office or program is in effect for at least six months, the office or program must submit a report on program outcomes, expenses, recommendations, and other pertinent information to the Office of the Children's Ombudsman and the Chairmen of the House Committees for Courts of Justice and on Health and Human Services and Appropriations and the Senate Committees for Courts of Justice and on Education and Health and Finance and Appropriations by November 1.
Patron - McClure

P HB934 Small claims court; representation of certain entities. Adds limited liability companies and other legal or commercial entities to those parties that may have representation by an owner, a general partner, an officer, a member, or an employee of such company or entity in small claims court. This bill is a recommendation of the Boyd-Graves Conference.
Patron - LeVere Bolling

P HB1264 Juvenile fines, costs, and fees; traffic infractions; judicial discretion. Provides that any court costs, fines, and fees assessed to a juvenile or his parent or guardian in circuit court and juvenile and domestic relations district court related to prosecutions of traffic infractions are discretionary. This bill was vetoed by the Governor.
Patron - Shin

P HB1420 Juveniles; adjudication of delinquency. Specifies that a delinquent child is a child 11 years of age or older who has committed a delinquent act. Currently, there is no minimum age for a child to be adjudicated delinquent. The bill provides that if a juvenile younger than 11 years of age is found to have committed a delinquent act, the juvenile shall not be proceeded upon as delinquent; however, the court may make any orders of disposition authorized for a child in need of services or a child in need of supervision. The bill includes in the definition of "child in need of services" a child younger than 11 years of age who has committed a delinquent act.
Finally, the bill includes in the offense of causing or encouraging acts rendering children delinquent, abused, etc., any person 18 years of age or older, including the parent of any child, who willfully contributes to, encourages, or causes any act, omission, or condition that causes a child younger than 11 years of age to commit a delinquent act. Under current law, any person who commits such offense is guilty of a Class 1 misdemeanor. This bill is identical to SB 23. This bill was vetoed by the Governor.
Patron - Watts

P SB23 Juveniles; adjudication of delinquency. Specifies that a delinquent child is a child 11 years of age or older who has committed a delinquent act. Currently, there is no minimum age for a child to be adjudicated delinquent. The bill provides that if a juvenile younger than 11 years of age is found to have committed a delinquent act, the juvenile shall not be proceeded upon as delinquent; however, the court may make any orders of disposition authorized for a child in need of services or a child in need of supervision. The bill includes in the definition of "child in need of services" a child younger than 11 years of age who has committed a delinquent act. Finally, the bill includes in the offense of causing or encouraging acts rendering children delinquent, abused, etc., any person 18 years of age or older, including the parent of any child, who willfully contributes to, encourages, or causes any act, omission, or condition that causes a child younger than 11 years of age to commit a delinquent act. Under current law, any person who commits such offense is guilty of a Class 1 misdemeanor. This bill is identical to HB 1420. This bill was vetoed by the Governor.
Patron - Locke

P SB236 Requests for reports of aggregated, nonconfidential case data; academic research. Allows a full-time faculty member of a baccalaureate public institution of higher education in the Commonwealth to request for the purposes of academic research, provided that such academic research has been approved through such public institution's institutional review board, a report for aggregated, nonconfidential case data for garnishment, unlawful detainer, and warrant in debt actions in a general district court. The bill provides that such report may include street addresses and the amount of money claimed in the action. The bill also requires any faculty member requesting the data to take all steps necessary to protect the privacy and security of such data and that such data shall not be subject to the Virginia Freedom of Information Act. This bill was vetoed by the Governor.
Patron - Hashmi

P SB398 Protective orders; respondent to notify court of change of address. Requires the respondent against whom a protective order has been issued to notify the court in writing within seven days of any change of residence while

such order is in effect, provided that such order has been properly served upon the respondent. In a proceeding involving a preliminary protective order, the bill provides that the court may require the respondent to notify the court in writing within seven days of any change of residence while such preliminary protective order is in effect. The bill also provides that any failure of a respondent to make such required notification shall be punishable by contempt.
Patron - Perry

P **SB460 Parental admission of minors for inpatient treatment.** Clarifies that for the purposes of admission of a minor to a willing mental health facility for inpatient treatment, the finding required to be made by a qualified evaluator that the minor appears to have a mental illness serious enough to warrant inpatient treatment may include a finding of substance abuse and such inpatient treatment may be related to such mental illness, which may include substance abuse. The bill also specifies that a temporary detention order shall not be required for a minor 14 years of age or older who objects to admission to be admitted to a willing facility upon the application of a parent. As introduced, this bill was a recommendation of the Virginia Commission on Youth. This bill is identical to HB 772.
Patron - Marsden

Failed

F **HB244 Protective order in case of family abuse; parents; minors.** Prohibits the parent of a minor from filing a petition for a family abuse protective order against such minor, provided that the minor has not otherwise been emancipated pursuant to law.
Patron - Martinez

F **HB295 Protective order in case of family abuse; parents; minors.** Prohibits the parent of a minor from filing a petition for a family abuse protective order against such minor, or from filing as next friend on behalf of his minor child against another of his minor children, provided that the minor has not otherwise been emancipated pursuant to law.
Patron - Martinez

F **HB470 Petition for child in need of services or in need of supervision.** Authorizes a guardian ad litem representing a child to file a petition for such child alleging he is in need of services or in need of supervision. The bill also provides that if an intake officer refuses to file a petition alleging that a child is in need of services or in need of supervision when such petition is sought by the parent or LEGAL GUARDIAN of such child, he shall provide a written explanation that details the reasons for such refusal and shall provide information to such parent oLEGAL GUARDIANan regarding any agency other than the court that can provide services for such child.
Patron - Martinez

F **HB635 Juveniles; confidentiality of Department records; law-enforcement access; victim notification.** Provides access to confidential Department of Juvenile Justice records to (i) any full-time or part-time employee of the Department of State Police or of a police department or sheriff's office that is a part of or administered by the Commonwealth or any political subdivision thereof and who is responsible for the enforcement of the penal, traffic, or motor vehicle laws of the Commonwealth having a need for juvenile offense history or identifying information of a juvenile and his family members, including juvenile names, parent or guardian names, addresses, dates of birth, photographs, and phone numbers, and (ii) with the exception of medical, psychiatric, and psychological records and reports, any victim, as defined in existing law, when release of the confidential information is only to notify such victim of a juvenile's release from the custody of a local or regional juvenile detention center, community group home, residential care facility, mental health facility, secure alternative placement, or commitment to the Department of Juvenile Justice for any offense such juvenile committed against such victim. This bill contains technical amendments.
Patron - Obenshain

F **HB717 Maximum number of judges in each judicial district.** Increases from five to six the maximum number of authorized juvenile and domestic relations district court judges in the Thirty-first Judicial District. This bill is a recommendation of the Committee on District Courts and is incorporated into HB 310.
Patron - Torian

F **HB835 Juvenile and domestic relations district courts; appointment of counsel or guardian ad litem; removal or appeal.** Specifies that any attorney appointed to represent a child or parent, guardian, or other adult at a hearing in the juvenile and domestic relations district court shall continue representation upon removal or appeal to the circuit court and upon the juvenile and domestic relations court being divested of the right to enter any further decrees or orders to determine custody, guardianship, visitation, or support. Under current law, such continued representation is discretionary upon appeal to the circuit court.
Patron - Cousins

F **HB1017 Discharge plans; portions provided to division superintendents in certain circumstances.** Provides that prior to the discharge of any minor or individual who has been admitted to inpatient treatment and is a student at a public elementary or secondary school, if the facility deems that the discharge of such minor poses a threat of violence or physical harm to self or others, only portions of the discharge plan related to the threat of violence or physical harm shall be provided to the division superintendent upon the completion of the discharge plan.
Patron - Wilt

F **HB1123 Maximum number of authorized judgeships in each judicial district.** Increases from six to seven the number of authorized general district court judgeships and increases from five to seven the number of authorized juvenile and domestic relations district court judgeships in the Thirteenth Judicial District.
Patron - Carr

F **HB1144 Children alleged to be abused or neglected; preliminary removal hearing; appointment of counsel for parent of such child.** Provides that at a preliminary removal hearing in cases in which a child is alleged to have been abused or neglected, the court shall appoint an attorney-at-law to represent such child's parent, guardian, or other adult standing in loco parentis if the court determines that such parent, guardian, or other adult standing in loco parentis is indigent, unless he has waived his right to representation or otherwise employed counsel. Under current law, any such appointment is made at an adjudicatory hearing on such removal after a preliminary removal order is issued.
Patron - Cordoza

F **SB208 Juveniles; confidentiality of Department records; law-enforcement access; victim notification.** Provides access to confidential Department of Juvenile Justice records to (i) any full-time or part-time employee of the

P **HB161 Arrest, prosecution, and disciplinary or administrative procedures and penalties for individuals experiencing or reporting overdoses while incarcerated.** Provides that no individual incarcerated in a local, regional, or state correctional facility shall be subject to arrest or prosecution for or disciplinary or administrative procedures or penalties related to the unlawful purchase, possession, or consumption of alcohol; possession of a controlled substance; possession of marijuana; procurement, sale, secretion, or possession of any chemical compound not lawfully received; intoxication in public; or possession of controlled paraphernalia if such individual seeks or obtains emergency medical attention for himself or another individual experiencing an overdose or is experiencing an overdose and another individual seeks or obtains emergency medical attention for him. The bill also provides that no correctional officer, deputy sheriff, or jail officer acting in good faith shall be found liable for false arrest if it is later determined that the person arrested was immune from prosecution or disciplinary procedures or penalties. This bill was vetoed by the Governor.

Patron - Seibold

P **HB173 Manufacture, import, sale, transfer, or possession of plastic firearms and unfinished frames or receivers and unserialized firearms prohibited; penalties.** Creates a Class 5 felony for any person who knowingly manufactures or assembles, imports, purchases, sells, transfers, or possesses any firearm that, after removal of all parts other than a major component, as defined in the bill, is not detectable as a firearm when subjected to inspection by the types of detection devices, including X-ray machines, commonly used at airports, government buildings, schools, correctional facilities, and other locations for security screening. The bill updates language regarding the types of detection devices that are used at such locations for detecting plastic firearms. Under current law, it is unlawful to manufacture, import, sell, transfer, or possess any plastic firearm and a violation is punishable as a Class 5 felony. The bill also creates a Class 1 misdemeanor, which is punishable as a Class 4 felony for a second or subsequent offense, making it unlawful for any person to knowingly possess a firearm or any completed or unfinished frame or receiver that is not imprinted with a valid serial number or to knowingly import, purchase, sell, offer for sale, or transfer ownership of any completed or unfinished frame or receiver, unless the completed or unfinished frame or receiver (i) is deemed to be a firearm pursuant to federal law and (ii) is imprinted with a valid serial number. The bill creates a Class 1 misdemeanor, which is punishable as a Class 4 felony for a second or subsequent offense, making it unlawful for any person to manufacture or assemble, cause to be manufactured or assembled, import, purchase, sell, offer for sale, or transfer ownership of any firearm that is not imprinted with a valid serial number. The portions of the bill prohibiting unfinished frames or receivers and unserialized firearms have a delayed effective date of January 1, 2025; however, the portions of the bill prohibiting the knowing possession of a firearm or any completed or unfinished frame or receiver that is not imprinted with a valid serial number have a delayed effective date of July 1, 2025. This bill is identical to SB 100. This bill received Governor's recommendations.

Patron - Simon

P **HB175 Carrying assault firearms in public areas prohibited; penalty.** Prohibits the carrying of certain semi-automatic center-fire rifles and shotguns on any public street, road, alley, sidewalk, or public right-of-way or in any public park or any other place of whatever nature that is open to the public, with certain exceptions. Under current law, the current prohibition on carrying certain shotguns and semi-automatic center-fire rifles and pistols applies to a narrower range of firearms, only in certain localities, and only when such firearms are loaded. This bill is identical to SB 99. This bill was vetoed by the Governor.

Patron - Simon

P **HB183 Storage of firearms in a residence where a minor or person prohibited from possessing a firearm is present; penalty.** Requires any person who possesses a firearm in a residence where such person knows that a minor or a person who is prohibited by law from possessing a firearm is present to store such firearm and the ammunition for such firearm in a locked container, compartment, or cabinet that is inaccessible to such minor or prohibited person. The bill provides that a violation is a Class 4 misdemeanor. The bill exempts (i) any person in lawful possession of a firearm who carries such firearm on or about his person and (ii) the storage of antique firearms and provides that the lawful authorization of a minor to access a firearm is not a violation of the bill's provisions. The bill also requires firearm dealers to post a notice stating such firearm storage requirements and the penalty for improperly storing such firearms. This bill is identical to SB 368. This bill was vetoed by the Governor.

Patron - Simon

P **HB267 Assault and battery; affirmative defense; penalty.** Provides an affirmative defense to prosecution of an individual for assault or assault and battery of certain specified individuals for which the enhanced Class 6 felony and six month mandatory minimum apply if such individual proves, by a preponderance of the evidence, that at the time of the assault or assault and battery (i) the individual's behaviors were a result of (a) mental illness or (b) a neurocognitive disorder, including dementia, or a neurodevelopmental disability, including a developmental disability or intellectual disability, such as autism spectrum disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association or (ii) the individual met the criteria for issuance of an emergency custody order.

The bill provides that if such individual does not prove that his behaviors were a result of his mental illness, intellectual disability, developmental disability, or neurocognitive disorder but the evidence establishes that his mental illness, intellectual disability, developmental disability, or neurocognitive disorder otherwise contributed to his behaviors, the finder of fact may find the accused guilty of a misdemeanor assault or assault and battery. The bill also provides that such affirmative defense shall not be construed to allow an affirmative defense for voluntary intoxication. This bill is identical to SB 357. This bill was vetoed by the Governor.

Patron - Watts

P **HB292 Drug Treatment Court Act; name change.** Renames the Drug Treatment Court Act as the Recovery Court Act. The bill also directs the Supreme Court of Virginia to rename the state Drug Treatment Court Advisory Committee as the Recovery Court Advisory Committee. This bill is identical to SB 725.

Patron - Ballard

P **HB351 Firearm locking device required for purchase of a firearm; warning against accessibility to children; penalty.** Requires any person who purchases a firearm to either (i) obtain or purchase from a licensed dealer a locking device for such firearm if a minor is present in such person's residence for 14 days or more in a calendar month or (ii) complete a certification statement on a form provided by the Department of State Police certifying that a minor is not present in such person's residence for 14 days or more in a calendar month, with exceptions enumerated in the bill. Accordingly,

shooting exercise meets the requirements to obtain a concealed handgun permit. The bill removes references to the National Rifle Association (the NRA) and the United States Concealed Carry Association from the Code that allow the organizations to certify ranges and instructors and for courses offered by them to serve as proof of demonstrated competence in firearms safety and training for the purpose of obtaining a concealed handgun permit or receiving training as a minor in the use of pneumatic guns. The bill has a delayed effective date of January 1, 2025. This bill was vetoed by the Governor.
Patron - Hope

P **HB798 Purchase, possession, or transportation of firearm following an assault and battery or stalking violation; prohibition period; penalty.** Prohibits a person who has been convicted of assault and battery, assault and battery of a family or household member, or stalking from purchasing, possessing, or transporting a firearm. The prohibition expires five years after the date of conviction, at which point the person's firearm rights are restored, unless he receives another disqualifying conviction. A person who violates the provisions of the bill is guilty of a Class 1 misdemeanor. The bill also extends from three years to five years the existing prohibition period for persons convicted of assault and battery of certain family or household members. This bill was vetoed by the Governor.
Patron - Hope

P **HB799 Concealed handgun permit applications; fingerprints required by local governments.** Requires an applicant for a concealed handgun permit or a renewal of such permit to submit fingerprints as part of the application. The bill provides that any demonstrated administrative costs associated with such fingerprints taken shall be the responsibility of and shall be assessed to the applicant. The bill has a delayed effective date of July 1, 2025. This bill was vetoed by the Governor.
Patron - Hope

P **HB895 Violation of protective orders; venue.** Allows a person to be prosecuted for a violation of a protective order charge in the jurisdiction where the party protected by the protective order resided at the time of such violation. This bill is identical to SB 211.
Patron - Bennett-Parker

P **HB926 Unlawful dissemination or sale of images of another; penalty.** Expands the current categories of images that are unlawful to disseminate or sell to include any videographic or still image that depicts another person whose genitals, pubic area, buttocks, or female breast are not exposed but such videographic or still image is obscene, as defined in the bill.
The bill adds to the statute of limitations for the misdemeanor offense of unlawful creation of the image of another to provide that a prosecution shall be commenced within five years of the commission of the offense or within one year of the date the victim discovers the offense or, by the exercise of due diligence, reasonably should have discovered the offense, whichever is later. The bill creates the same statute of limitations for the offense of unlawful dissemination or sale of the image of another. Current law starts the statute of limitations for the offense of unlawful creation of the image of another upon the commission of the offense.
Patron - Shin

P **HB928 Interference with commercial fishing vessels or activity; penalty.** Creates a Class 1 misdemeanor for any person who knowingly and intentionally interferes with or impedes the operation or commercial fishing activity, defined in the bill, of a commercial fishing vessel within the territorial waters of the Commonwealth. The bill deems a person to be ineligible for any hunting or fishing license for a period of one year upon a first conviction of this offense and for a period of three years upon a second or subsequent conviction. The bill also requires any person convicted of a violation of this offense to complete boating safety education.
Patron - Kent

P **HB991 Illegal gambling; exemptions.** Exempts from the provisions of Code prohibiting illegal gambling the placement or operation of or communication to and from data center equipment in the Commonwealth associated with the hosting of lottery games duly authorized by another state or jurisdiction and regulated and operated consistent with and exclusively for the benefit of such state or jurisdiction, provided that wagering on such games is legally authorized in such other state or jurisdiction and the individuals wagering on such games are required by the laws or regulations of such other state or jurisdiction to be physically located within the geographic bounds of such other state or jurisdiction at the time the wager is initiated or placed. This bill is identical to SB 540.
Patron - Maldonado

P **HB1174 Purchase of certain firearms; age requirement; penalty.** Prohibits any person under 21 years of age from purchasing a handgun or assault firearm, with exceptions for the purchase of an assault firearm by a law-enforcement officer, correctional officer, jail officer, or member of the Armed Forces of the United States, the Virginia National Guard, or the National Guard of any other state. Accordingly, the bill prohibits a licensed dealer from selling, renting, trading, or transferring from his inventory a handgun or assault firearm to any person under 21 years of age. A violation of either prohibition is a Class 6 felony. The bill also expands the definition of "assault firearm" as the term applies to criminal history record information checks. This bill is identical to SB 327. This bill was vetoed by the Governor.
Patron - Sickles

P **HB1195 Purchase of firearms; waiting period; penalty.** Provides that no person shall sell a firearm unless at least five days have elapsed from the time the prospective purchaser completes the written consent form to have a licensed dealer obtain criminal history record information, with exceptions enumerated in relevant law. This bill is identical to SB 273. This bill was vetoed by the Governor.
Patron - Hayes

P **HB1256 Larceny offenses; venue.** Allows grand larceny and embezzlement offenses to be prosecuted in any county or city where the victim of the larceny or embezzlement resides.
Patron - Kent

P **HB1443 Trial by jury; contact with jurors after trial prohibited; penalty.** Creates a Class 1 misdemeanor for any defendant who knowingly and intentionally contacts, with the intent to harass, intimidate, or threaten, a juror regarding such juror's service as a juror after a jury trial.
Patron - Davis

P **HJ76 Study; JLARC; effects of gun violence on communities; report.** Directs the Joint Legislative Audit and Review Commission to conduct a two-year study of the social, physical, emotional, and economic effects of gun violence on communities across the Commonwealth.
Patron - Anthony

devices, including X-ray machines, commonly used at airports, government buildings, schools, correctional facilities, and other locations for security screening. The bill updates language regarding the types of detection devices that are used at such locations for detecting plastic firearms. Under current law, it is unlawful to manufacture, import, sell, transfer, or possess any plastic firearm and a violation is punishable as a Class 5 felony.

The bill also creates a Class 1 misdemeanor, which is punishable as a Class 4 felony for a second or subsequent offense, making it unlawful for any person to knowingly possess a firearm or any completed or unfinished frame or receiver that is not imprinted with a valid serial number or to knowingly import, purchase, sell, offer for sale, or transfer ownership of any completed or unfinished frame or receiver, unless the completed or unfinished frame or receiver (i) is deemed to be a firearm pursuant to federal law and (ii) is imprinted with a valid serial number. The bill creates a Class 1 misdemeanor, which is punishable as a Class 4 felony for a second or subsequent offense, making it unlawful for any person to manufacture or assemble, cause to be manufactured or assembled, import, purchase, sell, offer for sale, or transfer ownership of any firearm that is not imprinted with a valid serial number. The portions of the bill prohibiting unfinished frames or receivers and unserialized firearms have a delayed effective date of January 1, 2025; however, the portions of the bill prohibiting the knowing possession of a firearm or any completed or unfinished frame or receiver that is not imprinted with a valid serial number have a delayed effective date of July 1, 2025. This bill is identical to HB 173. This bill received Governor's recommendations.

Patron - Ebbin

P **SB210** **Manufacture, importation, sale, etc., of auto sears; prohibition; penalty.** Prohibits the manufacture, importation, sale or offer to sell, possession, transfer, or transportation of an auto sear, defined in the bill as a device, other than a trigger activator, for use in converting a semi-automatic firearm to shoot automatically more than one shot, without manual reloading, by a single function of the trigger. A violation is punishable as a Class 6 felony. The bill also provides for the forfeiture of any auto sear concealed, possessed, transported, or carried in violation of the prohibition. This bill is identical to HB 22.

Patron - Perry

P **SB211** **Violation of protective orders; venue.** Allows a person to be prosecuted for a violation of a protective order charge in the jurisdiction where the party protected by the protective order resided at the time of such violation. This bill is identical to HB 895.

Patron - Perry

P **SB258** **Substantial risk orders; substantial risk factors and considerations.** Provides various factors that a judge or magistrate must consider for the purpose of determining probable cause prior to issuing an emergency substantial risk order or a substantial risk order. The bill provides that such factors shall include whether the person who is subject to the order (i) committed any acts of violence or criminal offenses resulting in injury to himself or another person within the six months prior to the filing of the petition; (ii) made any threats or used any physical force against another person that resulted in injury within the six months prior to the filing of the petition; (iii) violated any provision of a protective order issued or was arrested for stalking within the six months prior to the filing of the petition; (iv) was convicted of any offense that would prohibit such person from possessing a firearm; (v) engaged in any conduct within the year prior to the filing of the petition that demonstrated a pattern of violent acts or threats to another person, including any acts or threats made against family members, neighbors, coworkers, or toward schools or students or government buildings or employees; (vi) committed any acts of violence or criminal offenses against an animal within the six months prior to the filing of the petition; (vii) made any attempt or threat of suicide or any act, attempted act, or threat of self-harm that caused or may have caused serious bodily injury; or (viii) recently acquired a firearm or ammunition, with evidence of such recent acquisition provided by the petitioner. The bill also outlines various other factors that a judge or magistrate may consider for the purpose of issuing an emergency substantial risk order or a substantial risk order. The bill also provides that possession includes actual access or the potential to readily access a firearm for the purposes of finding if a person possesses a firearm or if such firearm shall be voluntarily relinquished. This bill was vetoed by the Governor.

Patron - Surovell

P **SB273** **Purchase of firearms; waiting period; penalty.** Provides that no person shall sell a firearm unless at least five days have elapsed from the time the prospective purchaser completes the written consent form to have a licensed dealer obtain criminal history record information, with exceptions enumerated in relevant law. This bill incorporates SB 55 and SB 551 and is identical to HB 1195. This bill was vetoed by the Governor.

Patron - Subramanyam

P **SB327** **Purchase of certain firearms; age requirement; penalty.** Prohibits any person under 21 years of age from purchasing a handgun or assault firearm, with exceptions for the purchase of an assault firearm by a law-enforcement officer, correctional officer, jail officer, or member of the Armed Forces of the United States, the Virginia National Guard, or the National Guard of any other state. Accordingly, the bill prohibits a licensed dealer from selling, renting, trading, or transferring from his inventory a handgun or assault firearm to any person under 21 years of age. A violation of either prohibition is a Class 6 felony. The bill also expands the definition of "assault firearm" as the term applies to criminal history record information checks. This bill is identical to HB 1174. This bill was vetoed by the Governor.

Patron - Salim

P **SB344** **Charitable gaming.** Amends charitable gaming law to allow, as a condition of receiving a charitable gaming permit or authorization to conduct electronic gaming, certain organizations to use a predetermined percentage of its receipts for expenses related to the rental of real property where such real property is involved in the operation of the organization and used for lawful religious, charitable, community, or educational purposes. The bill prohibits the Department of Agriculture and Consumer Services from promulgating electronic gaming regulations that prohibit (i) devices that display spinning, rotating, or rolling reels or animations or flashing lights; (ii) devices that accept vouchers; or (iii) the purchase and play of an electronic pull tab with a single press or touch of a button. This bill is identical to HB 523.

Patron - Reeves

P **SB357** **Assault and battery; affirmative defense; penalty.** Provides an affirmative defense to prosecution of an individual for assault or assault and battery of certain specified individuals for which the enhanced Class 6 felony and six month mandatory minimum apply if such individual proves, by a preponderance of the evidence, that at the time of the assault or assault and battery (i) the individual's behaviors were a result of (a) mental illness or (b) a neurocognitive disorder, including dementia, or a neurodevelopmental disability, including a developmental disability or intellectual disability, such as autism spectrum disorder, as defined in the most recent

edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association or (ii) the individual met the criteria for issuance of an emergency custody order.
The bill provides that if such individual does not prove that his behaviors were a result of his mental illness, intellectual disability, developmental disability, or neurocognitive disorder but the evidence establishes that his mental illness, intellectual disability, developmental disability, or neurocognitive disorder otherwise contributed to his behaviors, the finder of fact may find the accused guilty of a misdemeanor assault or assault and battery. The bill also provides that such affirmative defense shall not be construed to allow an affirmative defense for voluntary intoxication. This bill is identical to HB 267. This bill was vetoed by the Governor.
Patron - Boysko

P **SB362 First-time drug offenders.** Provides that any person who has not previously been convicted of any felony drug offense under relevant law or under any substantially similar statute of the United States or of any state may be eligible for first-time drug offender disposition. Under current law, such disposition is limited to any person who has not been convicted of any criminal drug offense. This bill is identical to HB 452. This bill received Governor's recommendations.
Patron - Ebbin

P **SB363 Removing, altering, etc., serial number on firearm; selling, giving, etc., or possessing firearm with removed, altered, etc., serial number; penalties.** Makes it a Class 1 misdemeanor for any person, firm, association, or corporation to knowingly possess any pistol, shotgun, rifle, machine gun, or any other firearm, except for an antique firearm, that has a serial number that has been removed, altered, changed, destroyed, or obliterated in any manner. The bill also makes it a Class 6 felony for any person, firm, association, or corporation to knowingly sell, give, or distribute any pistol, shotgun, rifle, machine gun, or any other firearm, except for an antique firearm, that has a serial number that has been removed, altered, changed, destroyed, or obliterated in any manner. This bill received Governor's recommendations.
Patron - Ebbin

Fidcuiary possession and disposal?

P **SB364 Elections; protection of electors and election officials; penalties.** Adds to the list of protected voters any current or former elector for President and Vice President of the United States and any person who is or has been a member of the State Board of Elections, the Commissioner of Elections, an employee of the Department of Elections, a member of a local electoral board, a general registrar, a deputy registrar, an employee in the office of the general registrar, or an officer of election. Protected voters are permitted by law to provide on the application for voter registration, in addition to the voter's residence street address, a post office box address located within the Commonwealth, which would be the address included on (i) lists of registered voters and persons who voted, (ii) voter registration records made available for public inspection, and (iii) lists of absentee voter applicants.
The bill makes it a Class 5 felony to, by bribery, intimidation, threats, coercion, or other means in violation of election laws, willfully and intentionally hinder or prevent an election official or employee of an election official from administering elections. Under current law, it is only a Class 5 felony to hinder or prevent an officer of election at a location being used for voting from holding an election. The bill also makes it a Class 5 felony to commit such acts against an elector for President and Vice President of the United States.
The bill creates a civil action for any election official, employee of an election official, or elector who is intimidated, threatened, or coerced by another person who thereby willfully and intentionally hinders or prevents, or attempts to hinder or prevent, such official, employee, or elector from fulfilling his duty . This bill received Governor's recommendations.
Patron - Ebbin

P **SB367 Task Force on Fentanyl and Heroin Enforcement established.** Creates the Task Force on Fentanyl and Heroin Enforcement whose purpose is to study ways to enhance the ability of law-enforcement officers throughout the Commonwealth to combat the illegal manufacturing, importation, and distribution of fentanyl, heroin, and other similar controlled substances. The bill requires the Task Force to meet at least annually and to report to the Governor and General Assembly by December 1 of each year regarding its activities and any recommendations.
Patron - DeSteph

P **SB368 Storage of firearms in a residence where a minor or person prohibited from possessing a firearm is present; penalty.** Requires any person who possesses a firearm in a residence where such person knows that a minor or a person who is prohibited by law from possessing a firearm is present to store such firearm and the ammunition for such firearm in a locked container, compartment, or cabinet that is inaccessible to such minor or prohibited person. The bill provides that a violation is a Class 4 misdemeanor. The bill exempts (i) any person in lawful possession of a firearm who carries such firearm on or about his person and (ii) the storage of antique firearms and provides that the lawful authorization of a minor to access a firearm is not a violation of the bill's provisions. The bill also requires firearm dealers to post a notice stating such firearm storage requirements and the penalty for improperly storing such firearms. This bill is identical to HB 183. This bill was vetoed by the Governor.
Patron - Boysko

P **SB383 Carrying a firearm or explosive material within Capitol Square or building owned or leased by the Commonwealth; exemptions; public institutions of higher education; penalty.** Limits the exemption from the prohibition on the carrying of any firearm or explosive material within any building owned or leased by the Commonwealth or agency thereof or any office where employees of the Commonwealth or any agency thereof are regularly present for the purpose of performing their official duties that currently applies to any property owned or operated by a public institution of higher education to instead apply to any individual within a building owned or operated by a public institution of higher education who possesses a weapon as part of such public institution of higher education's curriculum or activities or as part of any organization authorized by such public institution of higher education to conduct its programs or activities within such building, as such uses are approved through the law-enforcement or public safety unit of such institution. This bill is identical to HB 454. This bill was vetoed by the Governor.
Patron - Deeds

P **SB394 Carnal knowledge and sexual battery; persons detained or arrested by a law-enforcement officer; confidential informants, pretrial defendants or posttrial offenders; penalty.** Provides that an accused is guilty of carnal knowledge of a person serving as a confidential informant, defined in the bill, if he (i) is a law-enforcement officer; (ii) knows that such person is serving as a confidential informant for the law-enforcement agency where such officer is employed; and (iii) carnally knows, without use of force, threat, or intimidation, such confidential informant while such person is serving as a confidential informant or is expected to testify in a criminal case for which the confidential informant assisted the law-enforcement agency with its investigation. The

ellite office for the general election held the following year. The governing body of a county or city where a baccalaureate public institution of higher education meeting the enrollment threshold is located, or the general registrar serving such county or city, shall collaborate with the State Council of Higher Education for Virginia to select a location for the establishment and operation of a voter satellite office on such institution's campus. The location selected shall be within the student activity center on the institution's campus, unless such placement creates an undue burden on the operation of such institution, in which case the location selected shall be centrally located on the institution's campus.
Patron - Shin

C **HB1314** Elections; political campaign advertisements; advertisements sponsored by a person or political committee that is not a party committee.

C **HB1490** **Absentee voting in person; voter satellite offices; days and hours of operation.** Authorizes the governing body of any county or city establishing voter satellite offices for absentee voting in person to prescribe, by ordinance, the dates and hours of operation for such offices. The bill prohibits any reduction in the dates or hours of operation of such offices to be enacted within 60 days of any general election.
Patron - Reaser

C **SB270** **Elections; presidential primaries; ranked choice voting.** Allows political parties to hold presidential primaries using ballots that allow a voter to rank such party's candidates in his order of choice. The bill includes a reenactment clause.
Patron - Subramanyam

C **SB315** **Voter registration; registration of Department of Motor Vehicles customers, automatic update.** Provides that the information gathered by the Department of Motor Vehicles for a person who is already registered to vote is to be automatically transmitted to the Department of Elections for the purpose of updating an existing voter registration record name or address change and to return a voter to active status from inactive status, as appropriate. Under current law, a person must be presented with the option to decline to have his information transmitted to the Department of Elections before such information may be transmitted.
Patron - Salim

C **SB377** **Campaign finance; prohibited personal use of campaign funds; complaints, hearings, civil penalty, and advisory opinions.** Prohibits any person from converting contributions to a candidate or his campaign committee to personal use. Current law only prohibits such conversion of contributions with regard to disbursement of surplus funds at the dissolution of a campaign or political committee. The bill provides that a contribution is considered to have been converted to personal use if the contribution, in whole or in part, is used to fulfill any commitment, obligation, or expense that would exist irrespective of the person's seeking, holding, or maintaining public office but allows a contribution to be used for the ordinary and accepted expenses related to campaigning for or holding elective office, including the use of campaign funds to pay for the candidate's child care expenses that are incurred as a direct result of campaign activity. The bill provides that any person subject to the personal use ban may request an advisory opinion from the State Board of Elections on such matters. The bill directs the State Board of Elections to adopt emergency regulations similar to those promulgated by the Federal Election Commission to implement the provisions of the bill and to publish an updated summary of Virginia campaign finance law that reflects the State Board of Elections' and Attorney General's guidance on the provisions of such law that prohibit the personal use of campaign funds and any new regulations promulgated by the State Board of Elections.
Patron - Boysko

C **SB406** **Elections; political campaign advertisements; advertisements sponsored by a person or political committee that is not a party committee.** Prohibits any person from printing or circulating unofficial sample ballots unless they (i) are not printed on white paper, (ii) include the words "sample ballot," (iii) include the statement: "Paid for by [Name of the sponsor as defined by § 24.2-956.1]," and (iv) include the statement "Authorized by [Name of political party]" or "Not authorized by a political party."
Patron - Durant

Eminent Domain

Failed

F **HB735** **Eminent domain; offer to sell to former owner.** Provides that a former owner may enter into a contractual agreement or agree to a contractual provision waiving his right to receive an offer of sale from a condemnor. Under current law, any agreement or provision waiving such right is void and unenforceable.
Patron - Sewell

Financial Institutions and Services

Passed

P **HB648** **Contracts assigning rights to inheritance funds; legal rate of interest.** Provides that any contract entered into on or after July 1, 2024, pursuant to which a person receives a cash advance for assigning to a company or other entity a portion of such person's rights to receive inheritance funds from a will in a pending probate matter shall be considered a loan and any additional funds such person is obligated to pay under the terms of the contract shall be considered interest. The bill provides that such contract shall be subject to the legal rate of interest.
Patron - Coyner

P **HB692** **Financial institutions; reporting financial exploitation of elderly or vulnerable adults.** Permits a financial institution to allow an elderly or vulnerable adult, as defined in the bill, to submit and periodically update a list of trusted persons whom such financial institution or financial institution staff, as defined in the bill, may contact in the case of the suspected financial exploitation of such adult. The bill also permits a financial institution to conduct a training to instruct its staff on how to identify and report the suspected financial exploitation of an elderly or vulnerable adult internally at such financial institution, to a designated trusted contact, and to various other authorities. The bill directs the Bureau of Financial Institutions of the State Corporation Commission to develop and publish guidelines for such training by January 1, 2026. The bill provides that no financial institution staff that have received such training shall be liable in any civil or administrative proceeding for disclosing the suspected

financial exploitation of an elderly or vulnerable adult pursuant to the bill's provisions if such disclosure was made in good faith and with reasonable care. The bill provides that no financial institution that has provided such training shall be liable for any such disclosure by financial institution staff. This bill is identical to SB 174.
Patron - Maldonado

P **SB166 Financial institutions; certain payments required electronically.** Requires any financial institution that initiates an electronic fund transfer as payment for the sale to a consumer of a security issued by such financial institution to make available to the consumer the option of completing any payment of principal, interest, dividend, or other distribution related to the security via an electronic fund transfer.
Patron - Reeves

P **SB174 Financial institutions; reporting financial exploitation of elderly or vulnerable adults.** Permits a financial institution to allow an elderly or vulnerable adult, as defined in the bill, to submit and periodically update a list of trusted persons whom such financial institution or financial institution staff, as defined in the bill, may contact in the case of the suspected financial exploitation of such adult. The bill also permits a financial institution to conduct a training to instruct its staff on how to identify and report the suspected financial exploitation of an elderly or vulnerable adult internally at such financial institution, to a designated trusted contact, and to various other authorities. The bill directs the Bureau of Financial Institutions of the State Corporation Commission to develop and publish guidelines for such training by January 1, 2026. The bill provides that no financial institution staff that have received such training shall be liable in any civil or administrative proceeding for disclosing the suspected financial exploitation of an elderly or vulnerable adult pursuant to the bill's provisions if such disclosure was made in good faith and with reasonable care. The bill provides that no financial institution that has provided such training shall be liable for any such disclosure by financial institution staff. This bill is identical to HB 692.
Patron - Favola

Carried Over

C **HB343 Financial institutions; regulation of money transmitters; penalty.** Replaces existing state law regulating money transmitters with comprehensive provisions aimed at standardizing the regulation of money transmitters across the 50 states. The bill includes provisions for the licensure of money transmitters, supervision and implementation by the State Corporation Commission, acquisition of control of a licensee, mandatory disclosures, reporting and records requirements, authorized delegates, mandatory disclosures, prudential standards, and enforcement.
Patron - Cole

C **HB373 Financial institutions; reporting financial exploitation of elderly or vulnerable adults.** Permits a financial institution, as defined in the bill, to allow an elderly or vulnerable adult, as defined in the bill, to submit and periodically update a list of trusted persons whom such financial institution or financial institution staff, as defined in the bill, may contact in the case of suspected financial exploitation of such adult. In such a case, the bill also allows a financial institution or financial institution staff to convey such suspicion to one or more certain individuals, provided that the recipient of such conveyance is not the suspected perpetrator of financial exploitation. The bill provides that a financial institution or financial institution staff shall be immune from any criminal, civil, or administrative liability for any act taken or omission made in accordance with the bill's provisions.
Patron - Feggans

Fire Protection

Passed

P **HB852 Local government ordinances related to fire departments; billing on behalf of volunteer fire departments.** Provides that the governing body of any county, city, or town in which a fire department or fire company is established may make such ordinances in relation to the powers and duties of such fire departments or fire companies as it deems proper, including billing on behalf of volunteer fire departments for the provision of emergency medical services. This bill received Governor's recommendations.
Patron - Williams

Failed

F **HB484 Statewide Fire Prevention Code; State Fire Marshal; consumer fireworks; penalties.** Authorizes the use of consumer fireworks in the Commonwealth and distinguishes by definition consumer fireworks from display fireworks and permissible fireworks. The bill defines "consumer fireworks" as small fireworks devices (i) containing restricted amounts of pyrotechnic composition designed primarily to produce visible or audible effects by combustion and (ii) complying with certain federal regulations regarding composition and labeling. The bill also provides that the storage and transportation of consumer fireworks are to be considered the same hazard class as the storage and transportation of 1.4G explosives under the Statewide Fire Prevention Code (SFPC) and Uniform Statewide Building Code. The bill excludes from the provisions of the SFPC, unless prohibited by a local ordinance, (a) the sale of permissible or consumer fireworks; (b) any person using, igniting, or exploding permissible or consumer fireworks on residential or agricultural property with the consent of the owner of such property; or (c) such permissible or consumer fireworks when they are being transported from a locality where they were legally obtained to a locality where they are legally permitted. Current law only excludes sale of permissible fireworks or the use of such fireworks on private property. The bill also directs 10 percent of the sales and use tax revenue generated by the local sales and tax use on the sale of consumer or permissible fireworks to be allocated to a special fund used solely for providing funding for first responders, as defined in the bill. The bill contains technical amendments.
Patron - Garrett

F **HB1245 Secretary of Public Safety and Homeland Security; recruitment and development of volunteer firefighters; work group.** Directs the Secretary of Public Safety and Homeland Security to establish a work group to study the recruitment and development of volunteer firefighters with a specific focus on providing training to volunteer fire departments, volunteer fire companies, and volunteer firefighters in a cost-efficient and effective manner and to identify and recommend eliminating any barriers to the recruitment and development of volunteer firefighters.
Patron - Zehr

appropriated to the Department of Health to pay the cost of abortions for women who otherwise meet the financial eligibility criteria for services through the state plan for medical assistance services in cases in which (i) a pregnancy occurs as a result of rape or incest that is reported to a law-enforcement or public health agency or (ii) a physician certifies in writing that he believes the fetus will be born with a gross and totally incapacitating physical deformity or with a gross and totally incapacitating mental deficiency.
Patron - Griffin

F **HB1274 Official emblems and designations; cat; domestic shorthair.** Designates the domestic shorthair as the official cat of the Commonwealth.
Patron - Krizek

F **SB601 Capital outlay plan.** Updates the six-year capital outlay plan for projects to be funded entirely or partially from general fund-supported resources.
Patron - Lucas

Health

Passed

P **HB93 Alpha-gal syndrome; Board of Health; reportable disease list.** Directs the Board of Health to adopt regulations to include alpha-gal syndrome on the list of diseases that shall be required to be reported in accordance with the Code of Virginia. The bill has a delayed effective date of July 1, 2025.
Patron - Wachsmann

P **HB204 Maternal Mortality Review Team; membership.** Adds a representative of the Department of Corrections and a representative of the State Board of Local and Regional Jails, both appointed by the Governor, to the membership of the Maternal Mortality Review Team.
Patron - Simonds

P **HB220 Water facilities; staffing; licensed operators.** Requires sewage treatment works, classified waterworks, and classified water treatment facilities to employ a licensed operator. The bill establishes a protocol for responding to an unexpected vacancy of the licensed operator position. The bill also permits remote monitoring of the facility by the licensed operator upon a demonstration of sufficient technology for the remote operator to adequately monitor the waterworks or treatment facility and manage onsite operators.
Patron - Orrock

P **HB252 Sickle cell disease; statewide registry; collection of sickle cell disease case information; penalties; notification; annual report.** Creates a statewide registry of sickle cell disease patients to be maintained by the State Health Commissioner. The bill establishes: (i) standards and selection criteria for the collection of sickle cell disease information; (ii) penalties for unauthorized use of data from such registry; and (iii) notice requirements for patients whose personal identifying information has been submitted to such registry. The bill allows patients diagnosed with sickle cell disease to self-report information to the sickle cell disease registry. Under the bill, a patient has the right to opt out of having his information reported to the statewide sickle cell disease registry. The bill also directs the Commissioner to submit an annual report of the information obtained from the sickle cell disease registry to the Governor and the General Assembly by November 1 of each year.
Patron - Cole

P **HB255 Adult wellness screening; sickle cell disease or sickle cell trait.** Provides that every adult resident of the Commonwealth may be offered screening tests for sickle cell disease or the sickle cell trait and requires that the health care professional in charge of an adult's annual health examination provide education and appropriate counseling regarding the results of any such test that is performed.
Patron - Mundon King

P **HB291 Long-term services and supports screening; expedited screening; screening exemption; emergency.** Modifies existing provisions regarding the required long-term services and supports screening under the state plan for medical assistance services by creating greater flexibility for how screenings are completed under certain circumstances. Under the bill, any individual receiving inpatient services in an acute care hospital discharged to a nursing facility for skilled care only is not required to be screened prior to discharge from the hospital unless the individual requests the screening. The bill directs the Department of Medical Assistance Services to adopt emergency regulations to implement the provisions of the bill. This bill is identical to SB 24 and contains an emergency clause.
Patron - Cherry

Three day rule.
VAC reference pending.

P **HB353 Hospitals; emergency departments; licensed physicians.** Requires any hospital with an emergency department to have at least one licensed physician on duty and physically present at all times. Current law requires such hospitals to have a licensed physician on call, though not necessarily physically present on the premises, at all times. The bill has a delayed effective date of July 1, 2025 and is identical to SB 392.
Patron - Hope

P **HB354 Public pools; regulations.** Directs the Board of Health to adopt regulations governing swimming pools and other water recreational facilities operated for public use, including swimming pools and other water recreational facilities operated in conjunction with a tourist facility or health spa. This bill was vetoed by the Governor.
Patron - Hope

P **HB435 Law-enforcement officers; exposure to bodily fluids; petition to the general district court by local attorney for the Commonwealth.** Allows a local attorney for the Commonwealth in the county or city in which such exposure occurred to file a petition for an order requiring testing and disclosure of test results on behalf of a law-enforcement officer when a law-enforcement officer is directly exposed to the bodily fluid of a person in a manner that may, according to the then-current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses and such person refuses to submit to testing. Current law limits who may file a petition to the exposed law-enforcement officer or his employer.
Patron - Arnold

P **HB514 Advisory Council on Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections and Pediatric Acute-Onset Neuropsychiatric Syndrome; sunset.** Extends from July 1, 2020, to July 1, 2028, the sunset of the Advisory Council on Pediatric Autoimmune Neuropsychiatric Disorders Associated

P **HB820 Department of Medical Assistance Services; annual review of medication and treatment for sickle cell disease; report.** Directs the Department of Medical Assistance Services to conduct an annual review of all medications and forms of treatment for sickle cell disease, and services for enrollees with a diagnosis of sickle cell disease, that are eligible for coverage under the state plan for medical assistance services. The bill requires the Department to report its findings and recommendations by November 15 each year to the Chairmen of the House Committee on Health and Human Services and the Senate Committee on Education and Health and to the Joint Commission on Health Care.
Patron - Mundon King

P **HB831 Chief Medical Examiner; Maternal Mortality Review Team; work group; expansion plan; report.** Directs the Office of the Chief Medical Examiner and the Maternal Mortality Review Team to convene a work group to expand the work of the Maternal Mortality Review Team. The bill directs the work group to develop criteria and procedures related to the collection of maternal morbidity data. The bill specifies that the Maternal Mortality Review Team's expansion plan shall include certain plans for data collection, data review, and development and implementation of policies and recommendations. The work group is required to report its findings and provide its plan to the Chairmen of the House Committees on Appropriations and Health and Human Services and the Senate Committees on Finance and Appropriations and Education and Health by July 1, 2026.
Patron - Cousins

P **HB908 Department of Medical Assistances Services; financial eligibility standards for certain waivers providing services to individuals with developmental disabilities.** Directs the Department of Medical Assistance Services to amend the financial eligibility standards for individuals receiving services under the Family and Individual Support Waiver, Community Living Waiver, and Building Independence Waiver (the DD Waivers). The bill requires the Department, when determining financial eligibility for the DD Waivers, to disregard any Social Security Disability Insurance income above the maximum monthly Supplemental Security Income as determined by the U.S. Social Security Administration; however, such Social Security Disability Insurance income shall not be disregarded for purposes of determining an individual's patient pay obligation. The bill also requires the Department to (i) analyze the implications of such amendments to the financial eligibility standards for individuals under the DD waivers, which shall include a determination of the costs and the number of individuals who would benefit from such amendments and (ii) report its findings to the Chairmen of the Senate Committees on Education and Health and Finance and Appropriations and the House Committees on Health and Human Services and Appropriations no later than November 1, 2024. The bill sunsets on July 1, 2026. This bill is identical to SB 676.
Patron - Shin

P **HB1318 Department of Medical Assistance Services; Department of Behavioral Health and Developmental Services; 1915(c) Home and Community-Based Services Medicaid Waivers; state plan amendments; program rule modifications.** Directs the Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services to seek to modify the program rules for certain 1915(c) Home and Community-Based Services Medicaid Waivers to eliminate the requirement that in order for a legally responsible individual to receive reimbursement for personal care services, no one else be available to provide such services to the Medicaid member. This bill incorporates HB 1282.
Patron - Cole

P **HB1423 Department of Medical Assistance Services; publication of information related to home care services.** Directs the Department of Medical Assistance Services to annually publish on its website the average hourly payment rates for home care services for each type of service provided. The bill also requires the Department to publish the total number of Medicaid-paid home care claims and the number of Medicaid enrollees who received home care services in the prior year.
Patron - Cole

Useful for personal services agreements 1450.570 B 2.

P **HB1431 Alternative onsite sewage systems; approval of treatment units.** Requires the Department of Health to approve treatment units for alternative onsite sewage systems if they meet certain NSF/ANSI standards or certain testing requirements.
Patron - Hodges

P **HB1499 Virginia Health Workforce Development Authority; Virginia Health Care Career and Technical Training and Education Fund created; psychological practitioner defined; educational requirements for nursing faculty.** Modifies the enabling legislation for the Virginia Health Workforce Development Authority by adding four additional ex officio members to the Authority's Board of Directors, adding setting priorities for and managing graduate medical education programs to the duties of the Authority, specifying additional recipients of the Board's biennial report, and authorizing the Authority to partner with other agencies and institutions to obtain and manage health workforce data. The bill establishes the Virginia Health Care Career and Technical Training and Education Fund. The bill directs the Board of Nursing to add or remove certain educational requirements for members of the nursing faculty in specified nursing education programs and establishes a licensing procedure by the Board of Psychology for a psychological practitioner, as defined by the bill. The bill directs the Board of Nursing and the Board of Psychology to adopt regulations to implement relevant provisions of the bill to be effective no later than January 1, 2025. This bill is identical to SB 155.
Patron - Willett

P **HJ26 Uterine Fibroids Awareness Month.** Designates July, in 2024 and in each succeeding year, as Uterine Fibroids Awareness Month in Virginia.
Patron - Henson

P **SB24 Long-term services and supports screening; expedited screening; screening exemption; emergency.** Modifies existing provisions regarding the required long-term services and supports screening under the state plan for medical assistance services by creating greater flexibility for how screenings are completed under certain circumstances. Under the bill, any individual receiving inpatient services in an acute care hospital discharged to a nursing facility for skilled care only is not required to be screened prior to discharge from the hospital unless the individual requests the screening. The bill directs the Department of Medical Assistance Services to adopt emergency regulations to implement the provisions of the bill. This bill is identical to HB 291 and contains an emergency clause.
Patron - Locke

P **SB59 Department of Medical Assistance Services; Medicaid Works access and utilization work group; report.** Directs the Department of Medical Assistance Services

to convene a work group of relevant stakeholders to study and make recommendations to improve access to and successful utilization of the federal Medicaid Works program. The bill requires the work group to report its findings and recommendations to the Chairmen of the House Committees on Appropriations and Health and Human Services and the Senate Committees on Education and Health and Finance and Appropriations by November 1, 2024. This bill is a recommendation of the Virginia Disability Commission.
Patron - Favola

P **SB155 Virginia Health Workforce Development Authority; Virginia Health Care Career and Technical Training and Education Fund created; psychological practitioner defined; educational requirements for nursing faculty.** Modifies the enabling legislation for the Virginia Health Workforce Development Authority by adding four additional ex officio members to the Authority's Board of Directors, adding setting priorities for and managing graduate medical education programs to the duties of the Authority, specifying additional recipients of the Board's biennial report, and authorizing the Authority to partner with other agencies and institutions to obtain and manage health workforce data. The bill establishes the Virginia Health Care Career and Technical Training and Education Fund. The bill directs the Board of Nursing to add or remove certain educational requirements for members of the nursing faculty in specified nursing education programs and establishes a licensing procedure by the Board of Psychology for a psychological practitioner, as defined by the bill. The bill directs the Board of Nursing and the Board of Psychology to adopt regulations to implement relevant provisions of the bill to be effective no later than January 1, 2025. This bill is identical to HB 1499.
Patron - Head

P **SB237 Contraception; right to contraception; applicability; enforcement.** Establishes a right to obtain contraceptives and engage in contraception, as defined in the bill. The bill creates a cause of action that may be instituted against anyone who infringes on such right. This bill is identical to HB 609. This bill received Governor’s recommendations.
Patron - Hashmi

P **SB250 Department of Medical Assistance Services; remote ultrasound procedures; remote fetal nonstress tests.** Directs the Department of Medical Assistance Services to modify the state plan for medical assistance services to include a provision allowing for payment under certain conditions for remote ultrasound procedures and remote fetal nonstress tests.
Patron - Hashmi

P **SB274 Prescription Drug Affordability Board established; drug cost affordability review.** Establishes the Prescription Drug Affordability Board for the purpose of protecting the citizens of the Commonwealth and other stakeholders within the health care system from the high costs of prescription drug products. The bill requires the Board to meet in open session at least four times annually, with certain exceptions and requirements enumerated in the bill. Members of the Board are required to disclose any conflicts of interest, as described in the bill. The bill also creates a stakeholder council for the purpose of assisting the Board in making decisions related to drug cost affordability. The bill tasks the Board with identifying prescription, generic, and other drugs, as defined in the bill, that are offered for sale in the Commonwealth and, at the Board's discretion, conducting an affordability review of any prescription drug product. The bill lists factors for the Board to consider that indicate an affordability challenge for the health care system in the Commonwealth or high out-of-pocket costs for patients. The bill also provides that any person aggrieved by a decision of the Board may request an appeal of the Board's decision and that the Attorney General has authority to enforce the provisions of the bill. The bill provides that the Board shall establish no more than 12 upper payment limit amounts annually between January 1, 2025, and January 1, 2028.
The bill requires the Board to report its findings and recommendations to the General Assembly twice annually, beginning on July 1, 2025, and December 31, 2025. Provisions of the bill shall apply to state-sponsored and state-regulated health plans and health programs and obligate such policies to limit drug payment amounts and reimbursements to an upper payment limit amount set by the Board, if applicable, following an affordability review. The bill specifies that Medicare Part D plans shall not be bound by such decisions of the Board.
The bill also requires the nonprofit organization contracted by the Department of Health to provide prescription drug price transparency to provide the Board access to certain data reported by manufacturers. The bill has a delayed effective date of January 1, 2025, and is identical to HB 570. This bill was vetoed by the Governor.
Patron - Deeds

P **SB277 State Health Services Plan Task Force; certificate of public need; recommendations.** Directs the Board of Health to convene the State Health Services Plan Task Force to make recommendations on expedited review of projects subject to certificate of public need requirements.
Patron - Hashmi

P **SB325 Vital records; birth certificates; adoption; members of the military.** Directs the State Registrar to expedite issuance of a new birth certificate upon receipt of certain documentation for a person born in the Commonwealth if at least one adoptive parent is an active duty or retired member of the military or military reserves. The bill directs the court decreeing the adoption to deliver such records to the State Registrar no later than five business days from such decree. This bill is identical to HB 649.
Patron - Roem

P **SB392 Hospitals; emergency departments; licensed physicians.** Requires any hospital with an emergency department to have at least one licensed physician on duty and physically present at all times. Current law requires such hospitals to have a licensed physician on call, though not necessarily physically present on the premises, at all times. The bill has a delayed effective date of July 1, 2025 and is identical to HB 353.
Patron - Pekarsky

P **SB537 Board of Health; hospital regulations; use of smoke evacuation systems during surgical procedures.** Requires the Board of Health to amend its regulations to require that every hospital where surgical procedures are performed adopt a policy requiring the use of a smoke evacuation system for all planned surgical procedures. The bill defines "smoke evacuation system" as smoke evacuation equipment and technologies designed to capture, filter, and remove surgical smoke at the site of origin and to prevent surgical smoke from making ocular contact or contact with a person's respiratory tract. The bill has a delayed effective date of July 1, 2025, and is identical to HB 763.
Patron - Bagby

P **SB610 Department of Medical Assistance Services; Department of Behavioral Health and Developmental Services; slot-retention requests; Developmental Disability waivers; sunset.** Directs the Department of Medical

Assistance Services and the Department of Behavioral Health and Developmental Services to amend their regulations to allow for support coordinators to request and subsequently obtain approval of consecutive waiver slot-retention requests for a period of up to 365 calendar days for individuals who have been assigned a Developmental Disability waiver slot. Current regulations allow for four consecutive 30-day slot-retention extensions. The bill sunsets on June 30, 2026, and is identical to HB 577.

Patron - Suetterlein

P **SB620 Long-term services and support screening; PACE programs; emergency.** Allows qualified staff of programs of all-inclusive care for the elderly (PACE) to conduct the required long-term services and supports screening in accordance with requirements established by the Department of Medical Assistance Services. Under the bill, when a screening team determines that it is unable to complete a long-term services and supports screening within 30 days, or an individual requests enrollment in a PACE program, the screening team shall decide which entity can most expeditiously conduct the screening. Under the bill, qualified staff of a PACE program shall conduct the screening if the screening team determines that it is the most expeditious option. The bill directs the Department to adopt emergency regulations to implement the provisions of the bill and contains an emergency clause. This bill is identical to HB 729.

Patron - Pillion

P **SB676 Department of Medical Assistances Services; financial eligibility standards for certain waivers providing services to individuals with developmental disabilities.** Directs the Department of Medical Assistance Services to amend the financial eligibility standards for individuals receiving services under the Family and Individual Support Waiver, Community Living Waiver, and Building Independence Waiver (the DD Waivers). The bill requires the Department, when determining financial eligibility for the DD Waivers, to disregard any Social Security Disability Insurance income above the maximum monthly Supplemental Security Income as determined by the U.S. Social Security Administration; however, such Social Security Disability Insurance income shall not be disregarded for purposes of determining an individual's patient pay obligation. The bill also requires the Department to (i) analyze the implications of such amendments to the financial eligibility standards for individuals under the DD waivers, which shall include a determination of the costs and the number of individuals who would benefit from such amendments and (ii) report its findings to the Chairmen of the Senate Committees on Education and Health and Finance and Appropriations and the House Committees on Health and Human Services and Appropriations no later than November 1, 2024. The bill sunsets on July 1, 2026. This bill is identical to HB 908.

Patron - Ebbin

Failed

F **HB8 Medical Ethics Defense Act established.** Establishes the right of a medical practitioner, health care institution, or health care payer not to participate in or pay for any medical procedure or service that violates such medical practitioner's, health care institution's, or health care payer's conscience, as those terms and conditions are defined in the bill. The bill provides protections for medical practitioners who disclose violations of the bill or report violations of laws or ethical guidelines for the safe provision of any medical procedure or service. The bill also provides a private right of action for any party harmed by violations of the bill.

Patron - Ware

F **HB37 Loan repayment programs; mental health professionals.** Creates a loan repayment program for persons who have worked as mental health professionals in the Commonwealth for at least five years.

Patron - Clark

F **HB52 Alkaline hydrolysis; registration; regulations.** Establishes a registration requirement for alkaline hydrolysis providers. The bill defines alkaline hydrolysis and adds alkaline hydrolysis and hydrolyzed remains to statutes dealing with cremation and cremains. The bill grants the Board of Funeral Directors and Embalmers the power to regulate and inspect alkaline hydrolysis providers and their operations. The bill requires the Board of Funeral Directors and Embalmers to consult with the Department of Environmental Quality, the Department of Health, and representatives of wastewater treatment facilities and funeral service associations to promulgate regulations related to alkaline hydrolysis.

Patron - Taylor

F **HB87 Board of Health; hospital regulations; patient drug testing.** Requires the Board of Health to amend its regulations to require hospitals to test patients who are presenting with overdose symptoms for fentanyl and to test for fentanyl, marijuana, amphetamines, opioids, and phencyclidine as a part of any routine drug screening administered to a patient.

Patron - Green

F **HB127 Department of Medical Assistance Services; Department of Behavioral Health and Developmental Services; 1915(c) Home and Community Based Services Medicaid Waivers; state plan amendments; program rule modifications.** Directs the Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services to seek to modify the program rules for 1915(c) Home and Community Based Services Medicaid Waivers to disregard Social Security Disability Insurance in calculating eligibility for 1915(c) Home and Community Based Services Medicaid Waivers.

Patron - Watts

F **HB137 Emergency medical services regulations; police dogs.** Requires the State Board of Health to promulgate regulations, in consultation with the State Veterinarian, to provide emergency treatment to police dogs injured in the line of duty and for the transportation of such police dogs by emergency medical services vehicles to veterinary care facilities equipped to provide emergency treatment to such dogs.

Patron - Campbell

F **HB169 Task Force on Maternal Health Data and Quality Measures; report.** Directs the State Health Commissioner to reestablish the Task Force on Maternal Health Data and Quality Measures for the purpose of evaluating maternal health data collection processes to guide policies in the Commonwealth to improve maternal care, quality, and outcomes for all birthing people in the Commonwealth. The bill directs the Task Force to report its findings and conclusions to the Governor and General Assembly by December 1 of each year regarding its activities. This bill reestablishes the Task Force on Maternal Health Data and Quality Measures that concluded on December 1, 2023. This bill was incorporated into HB 781.

Patron - Keys-Gamarra

ent. The bill establishes a duty for a government agent with knowledge that a minor has exhibited symptoms of gender dysphoria or gender nonconformity or otherwise demonstrates a desire to be treated in a manner incongruent with the minor's sex to immediately notify each of the minor's parents, guardians, or custodians in writing, with descriptions of relevant circumstances. The bill prohibits discrimination against persons (i) providing information regarding violations of the Act to their employer or specified public entities or (ii) who make disclosures under the Act of information that evinces any violation of law, rule, or regulation; any violation of any standard of care or other ethical guidelines for the provision of health care service; or gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety. The bill establishes a civil action for any violation of the Act by a clinic, health care system, medical professional, or other responsible person with a two-year statute of limitations. The bill prohibits political subdivisions of the Commonwealth from enacting, adopting, maintaining, or enforcing any measure that interferes with the professional conduct and judgment of a mental health care professional or counselor undertaken within the course of treatment and communication with clients, patients, other persons, or the public. The bill provides for enforcement by the Attorney General or a mental health care professional or counselor through an action for injunctive relief and allows a mental health care professional to recover reasonable attorney fees and reasonable costs incurred in obtaining an injunction. The bill waives sovereign immunity to suit and immunity from liability under this statute.
Patron - Peake

Carried Over

C **HB33** **Commissioner of Health; work group to study the occurrence of microplastics in the Commonwealth's public drinking water; report.** Directs the Commissioner of Health to convene a work group to study the occurrence of microplastics in the Commonwealth's public drinking water and develop recommendations for the reduction of microplastics in the Commonwealth's public drinking water. The bill requires the work group to report its findings and recommendations to the Governor and the Chairmen of the House Committees on Agriculture, Chesapeake and Natural Resources and Health, Welfare and Institutions and the Senate Committees on Agriculture, Conservation and Natural Resources and Education and Health by December 1, 2024.
Patron - Clark

C **HB80** **Advisory Council on Breakthrough Therapies for Veteran Suicide Prevention; established; report.** Establishes the Advisory Council on Breakthrough Therapies for Veteran Suicide Prevention to advise the State Health Commissioner on the regulations and infrastructure necessary to support clinical access to and training for medication-assisted U.S. Food and Drug Administration breakthrough therapies for veteran suicide prevention. The bill requires the Commissioner of Health to report annually by December 1 to the Governor and the General Assembly regarding its activities and recommendations. The Council has a sunset date of July 1, 2027.
Patron - Jones

C **HB286** **Task Force on Maternal Health Data and Quality Measures; report.** Directs the State Health Commissioner to reestablish the Task Force on Maternal Health Data and Quality Measures for the purpose of evaluating maternal health data collection processes to guide policies in the Commonwealth to improve maternal care, quality, and outcomes for all birthing people in the Commonwealth. The bill directs the Task Force to report its findings and conclusions to the Governor and General Assembly by December 1 of each year regarding its activities. This bill reestablishes the Task Force on Maternal Health Data and Quality Measures that concluded on December 1, 2023.
Patron - McQuinn

C **HB499** **Department of Medical Assistance Services; Department of Behavioral Health and Developmental Services; Medicaid Waivers; program rule modifications.** Directs the Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services to modify the program rules for certain Medicaid waivers to eliminate the requirement that certain visits for individuals enrolled in Family and Individual Support Waivers, Community Living Waivers, Building Independence Waivers, and CCC Plus Waivers be conducted face-to-face.
Patron - Cohen

C **HB550** **Adult adoptee access to original birth certificate.** Grants any adoptee 18 years of age or older access to his original birth certificate.
Patron - Walker

C **HB620** **Medical assistance services; payment for essential hygiene products.** Directs the State Board of Health to include a provision for payment of medical assistance for the purchase of essential hygiene products in the state plan for medical assistance services.
Patron - Price

C **HB628** **Certificate of public need; hospitals licensed by the Department of Behavioral Health and Developmental Services; psychiatric beds.** Excludes from the list of medical care facilities for which a certificate of public need is required hospitals licensed as a provider by the Department of Behavioral Health and Developmental Services. The bill excludes the following from the list of projects for which a certificate of public need is required for certain medical care facilities: (i) an increase or relocation of psychiatric beds licensed by the Department, (ii) the introduction of any psychiatric service when such medical care facility has not provided such service in the previous 12 months, and (iii) the conversion of beds to psychiatric beds. The bill also modifies the list of projects for which a certificate of public need is required for certain medical care facilities by requiring a certificate for the conversion of any psychiatric inpatient beds to nonpsychiatric inpatient beds. Under current law, a certificate is required for the conversion of a psychiatric bed to a nonpsychiatric bed only when the psychiatric bed was approved pursuant to a Request for Applications (RFA).
Patron - Orrock

C **HB886** **Certified nursing facilities; administrative sanctions; facilities subject to minimum standards.** Amends the administrative sanctions that may be imposed on certified nursing facilities in relation to compliance with staffing requirements. The bill directs the State Health Commissioner, in determining whether or not to impose sanctions, to make the determination of whether a certified nursing facility was located in a medically underserved area that severely limited the ability of the certified nursing facility to recruit and retain direct care staff. The bill requires nursing facilities subject to a corrective action plan to demonstrate compliance with the corrective action plan on a quarterly basis. Under the bill, in determining whether a corrective action plan is needed, the Commissioner shall consider certain evidence of direct care staff hours, unless the facility has had a change in ownership. The bill changes from three to two the number of corrective action plans after which, if a a certified nursing facility fails to show compliance or improvement, the Commissioner may

required minimum amount of professional liability coverage for nursing homes and certified nursing facilities is the amount per occurrence. The bill also requires such coverage to be noneroding, i.e., the coverage limits are not reduced by legal costs.
Patron - Obenshain

C **SB592 Department of Medical Assistance Services; Preferred Drug List/Common Core Formulary; approval of a nonpreferred drug.** Directs the Department of Medical Assistance Services to eliminate the requirement that a patient try and fail a drug from the Preferred Drug List/Common Core Formulary in the six months immediately prior to approval of a nonpreferred drug when such patient has previously tried the drug from the Preferred Drug List/Common Core Formulary and experienced harmful side effects.
Patron - Salim

C **SB594 Department of Health; Office of Emergency Medical Services EMS Advisory Board; emergency medical personnel; career fatigue and wellness program.** Directs the Department of Health's Office of Emergency Medical Services EMS Advisory Board to examine the eligibility requirements for emergency medical personnel to join a professional program addressing career fatigue and wellness. The bill requires the Board to report its findings and recommendations to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by October 1, 2024.
Patron - McPike

C **SB636 Transcranial magnetic stimulation treatment; pilot program.** Directs the Department of Veterans Services to establish a pilot program with two locations to make electroencephalogram (EEG) combined transcranial magnetic stimulation treatment available for certain military members, veterans, first responders, law-enforcement officers, and certain agents of federal agencies, and family members of the aforementioned individuals. The bill requires the Department to establish regulations for administration of the pilot program.
Patron - Locke

C **SB661 Nursing facilities; electronic monitoring in resident rooms.** Gives residents of nursing facilities the right to place electronic monitoring devices in their rooms. "Electronic monitoring" is defined in the bill as video or audio monitoring or recording of residents of a nursing facility as a means of monitoring resident wellbeing.
Patron - Craig

Already law.

Highways and Other Surface Transportation Systems

Passed

P **HB5 Town of Leesburg Parking Authority.** Authorizes the creation of the Town of Leesburg Parking Authority. The bill grants to the Authority various powers, including the authority to construct, operate, and lease parking facilities, contract with outside entities, issue revenue bonds and revenue refunding bonds, and acquire property. The bill also exempts the Authority from taxation.
Patron - Martinez

P **HB74 Unpaved secondary highway funds.** Clarifies that the improvement of nonsurface treated secondary highways includes improvements other than paving, as described in the bill. The bill also clarifies that the local governing body of the county receiving funds for such improvements will select the highways or highway segments to be improved, after consulting with the Department of Transportation. This bill is identical to SB 644.
Patron - Reid

P **HB92 Percy Lee House, III Memorial Bridge.** Designates the bridge on Otterdam Road over Interstate 95 in Greensville County the "Percy Lee House, III Memorial Bridge." This bill is identical to SB 323.
Patron - Wachsmann

P **HB143 Utility work database.** Requires the Department of Transportation to establish and maintain a publicly accessible database and map of all utility work that has been approved by the Department and will occur within a highway right-of-way in a residential neighborhood. The bill has a delayed effective date of January 1, 2025.
Patron - Reid

P **HB201 Certain transportation entities; membership.** Requires, rather than permits, the four members of the Northern Virginia Transportation Commission, the two members of the Potomac and Rappahannock Transportation Commission, and the two members of the Northern Virginia Transportation Authority who are appointed by the Speaker of the House of Delegates to be members of the House of Delegates. This bill incorporates HB 1173 and HB 1175.
Patron - Krizek

P **HB840 Special license plates; 250th anniversary of the American Revolution.** Authorizes the issuance of revenue-sharing special license plates marking the 250th anniversary of the American Revolution. The bill provides that the prepaid application requirements for special license plates shall not apply to such plates, that the provisions of the bill expire on July 1, 2032, that such plates shall not be newly issued on or after such date, and that such plates may continue in use for a period of time determined by the Commissioner of the Department of Motor Vehicles. This bill is identical to SB 216.
Patron - Austin

P **HB1254 Bridges; state of good repair; allocation of funds.** Designates bridges with a general condition rating, defined in the bill, of no more than five for at least one major bridge component as eligible for state of good repair funds. Currently, bridges must be structurally deficient to be eligible. The bill authorizes the use of state of good repair funds for improvements anticipated to extend the useful life of a bridge by at least 10 years. The bill applies to new project allocations made by the Commonwealth Transportation Board after June 1, 2025.
Patron - Runion

P **HB1331 Conveyance of easement; Department of State Police and Department of Transportation.** Authorizes the conveyance of an easement in Campbell County by the Department of State Police in conjunction with the Department of Transportation.
Patron - Walker

P **SB158 Northern Virginia Transportation Authority; technical advisory committee; appointments.** Provides that six members of the Northern Virginia Transportation Authority's technical advisory committee are appointed

mination from the carrier's provider panel, except when a provider is terminated for cause. The bill provides that for an enrollee who has an existing provider-patient relationship with a provider, and, at the time of the provider's termination, (i) has been medically confirmed to be pregnant, the provider is required to continue care through the postpartum period; (ii) is determined to be terminally ill, the provider is required to continue care for the remainder of the enrollee's life; (iii) has been determined by a medical professional to have a life-threatening condition, the provider is required to continue care for up to 180 days; and (iv) is admitted to and receiving treatment in an inpatient facility, the provider is required to continue care until the enrollee is discharged from the inpatient facility. Under current law, the carrier is required to permit the provider to provide such continuity of care. The bill provides that the continuity of care provisions also apply to plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act.
Patron - Orrock

P **HB238 Health insurance; coverage for colorectal cancer screening.** Requires health insurers to provide coverage for examinations and laboratory tests related to colorectal cancer screening in accordance with the most recently published recommendations established by the U.S. Preventive Services Task Force for colorectal cancer screening for which a rating of A or B is in effect with respect to the individual involved. The bill requires such coverage to include coverage of a follow-up colonoscopy after a positive noninvasive stool-based screening test or direct visualization screening test. The bill prohibits such coverage from being subject to any deductible, coinsurance, or any other cost-sharing requirements for services received from participating providers. The provisions of the bill apply to individual or group accident and sickness insurance policies, individual or group accident and sickness subscription contracts, or health care plans delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2025.
Patron - McQuinn

P **HB591 Commonwealth Health Reinsurance Program; payment parameters.** Requires the State Corporation Commission, in setting the payment parameters for the upcoming benefits year, to set such payment parameters at levels designed to achieve the premium reduction target established in the general appropriation act or, if such target is not established in the general appropriation act, the premium reduction target of the previous benefit year.
Patron - Sickles

P **HB595 Insurance; conducting business by electronic means.** Authorizes a plan sponsor of a health benefit plan, including a dental or vision benefit plan, to agree on behalf of a party enrolled in the sponsored health benefit plan to conduct business by electronic means, provided that the plan sponsor, prior to agreeing on behalf of the party, has confirmed that the party routinely uses electronic communications during the normal course of employment and has provided notice to the party regarding the ability to opt out of using electronic means at any time.
Patron - Sullivan

P **HB601 Health insurance; emergency services; mobile crisis response services.** Provides that emergency services, with respect to an emergency medical condition, include, as it relates to any mental health services or substance abuse services rendered at a behavioral health crisis service provider, (i) a behavioral health assessment that is within the capability of a behavioral health crisis service provider, including ancillary services routinely available to evaluate such emergency medical condition, and (ii) such further examination and treatment, to the extent that they are within the capabilities of the staff and facilities available at the behavioral health crisis service provider, as are required so that the patient's condition does not deteriorate. This bill is identical to SB 543.
Patron - Kilgore

P **HB819 Health insurance; coverage for contraceptive drugs and devices.** Requires health insurance carriers to provide coverage, under any health insurance contract, policy, or plan that includes coverage for prescription drugs on an outpatient basis, for contraceptive drugs and contraceptive devices, as defined in the bill, including those available over-the-counter. The bill prohibits a health insurance carrier from imposing upon any person receiving contraceptive benefits pursuant to the provisions of the bill any copayment, coinsurance payment, or fee, except in certain circumstances. This bill is identical to SB 238. This bill received Governor's recommendations.
Patron - Mundon King

P **HB935 Health insurance; coverage for doula care services.** Requires health insurers, corporations providing health care subscription contracts, and health maintenance organizations whose policy, contract, or plan includes coverage for obstetrical services to provide coverage for doula care services provided by a state-certified doula. The bill requires such coverage to include coverage for at least eight visits during the antepartum or postpartum period and support during labor and delivery. The bill provides that health insurance carriers are (i) not required to pay for duplicate services actually rendered by both a state-certified doula and another health care provider and (ii) prohibited from requiring supervision, signature, or referral by any other health care provider as a condition of reimbursement for doula care services, except when those requirements are also applicable to other categories of health care providers. Such provisions of the bill are subject to a reenactment clause. The bill also requires the Health Insurance Reform Commission to consider coverage for doula care services in its review of the essential health benefits benchmark plan and to include such coverage in its recommendation to the General Assembly unless a compelling reason for excluding such coverage is identified. This bill is identical to SB 118.
Patron - LeVere Bolling

P **HB987 Proton radiation therapy; clinical evidence for decisions on coverage.** Permits a health insurance carrier to consider (i) coverage of a proton radiation therapy treatment by Medicare, Medicaid, or any other governmental health care coverage for any type of cancer or (ii) a recommendation of proton radiation therapy by a patient's treating physician or radiation oncologist as a sufficient standard of clinical evidence to justify coverage of proton radiation therapy.
Patron - Maldonado

P **HB1060 Long-term care insurance; rate increases; notice requirements.** Requires an insurer providing long-term care insurance policies to issue a written notice to each policyholder of the insurer's filing for a rate increase with the State Corporation Commission within 60 days of making such filing. Additionally, the bill requires the insurer to (i) if the Commission denies the rate increase, issue a written notice to each policyholder of the Commission's final decision to deny the rate increase within 90 days of such decision or (ii) if the Commission approves the rate increase, issue a written notice to each policyholder of the rate increase at least 90 days before its effective date that includes certain information listed in the bill. The bill requires the Commission, in reviewing requests to increase long-term care insurance rates, to consider,

to the extent practicable, how the rate increase will impact policyholders.

Patron - Tran

P HB1132 Insurance; dental carriers; annual report. Requires each dental carrier, beginning in 2025, to annually, on or before April 30, file with the State Corporation Commission a report that includes the actual loss ratio, defined in the bill, for the preceding calendar year and any such other information as the Commission may require. The bill requires the Commission to post such reports on its website. The bill requires the Bureau of Insurance to evaluate the effectiveness of informing the public on the information being reported and to make recommendations, if any, on the continuation or modification of the obligation of dental carriers to report such information. The bill also requires the Commission to convene a work group of interested stakeholders to determine if any revisions are necessary to the Code of Virginia regarding ethics and fairness in dental carrier business practices and of health care providers of dental services. The work group is required to report its recommendations to the Chairs of the House Committee on Labor and Commerce and the Senate Committee on Commerce and Labor on or before October 1, 2024. This bill is identical to SB 257.

Patron - Hayes

P HB1134 Health insurance; prior authorization. Requires that any provider contract between a carrier and a participating health care provider contain specific provisions that require that if a prior authorization request is approved for prescription drugs and such prescription drugs have been scheduled, provided, or delivered to the patient consistent with the authorization, the carrier shall not revoke, limit, condition, modify, or restrict that authorization unless (i) there is evidence that the authorization was obtained based on fraud or misrepresentation; (ii) final actions by the U.S. Food and Drug Administration, other regulatory agencies, or the manufacturer remove the drug from the market, limit its use in a manner that affects the authorization, or communicate a patient safety issue that would affect the authorization alone or in combination with other authorizations; (iii) a combination of drugs prescribed would cause a drug interaction; or (iv) a generic or biosimilar is added to the prescription drug formulary. The bill provides that such provisions do not require a carrier to cover any benefit not otherwise covered or cover a prescription drug if the enrollee is no longer covered by a health plan on the date the prescription drug was scheduled, provided, or delivered. This bill is identical to SB 98.

Patron - Willett

P HB1257 Insurance; coverage for the diminished value of personal property. Requires any insurer who issues or delivers a new or renewal homeowner's insurance policy or a stand-alone policy that covers scheduled personal property in the Commonwealth to offer in writing a provision providing coverage for the diminution in the value of any such scheduled personal property, if the schedule provides for the repair of such property. Under the bill, the diminution in value of the personal property is the amount, if any, by which the market value of the personal property immediately following the completion of repair of the damage to the personal property is less than the market value of the personal property immediately prior to the damage and the change in market value is a direct result of damage from the covered loss. The provisions of the bill shall apply to every such policy that is issued, delivered, or renewed by an insurer licensed in the Commonwealth on or after July 1, 2025.

Patron - Milde

P HB1402 Health insurance; pharmacy benefits managers; reporting requirements; civil penalty. Provides that a person that violates the existing requirement to obtain a license prior to providing pharmacy benefits management services or otherwise acting as a pharmacy benefits manager may be subject to a civil penalty of $5,000 for each day on which such violation occurs. The bill adds additional requirements to existing reporting requirements for insurance carriers relating to pharmacy benefits managers. Such additional requirements include (i) the aggregate amount of a pharmacy benefits manager's retained rebates, as defined in the bill; (ii) a pharmacy benefits manager's aggregate retained rebate percentage, as defined in the bill; and (iii) the aggregate amount of administrative fees received by a pharmacy benefits manager. This bill is identical to SB 660.

Patron - Reaser

P SB87 Health insurance provider panels; incentives for mental health services. Allows a provider panel contract between a carrier and a primary care provider to include provisions that promote comprehensive screening using evidence-based tools for mental health needs and appropriate referrals by primary care providers to mental health services that may be provided on-site, via telehealth on site, or through an off-site referral.

Patron - Favola

P SB98 Health insurance; prior authorization. Requires that any provider contract between a carrier and a participating health care provider contain specific provisions that require that if a prior authorization request is approved for prescription drugs and such prescription drugs have been scheduled, provided, or delivered to the patient consistent with the authorization, the carrier shall not revoke, limit, condition, modify, or restrict that authorization unless (i) there is evidence that the authorization was obtained based on fraud or misrepresentation; (ii) final actions by the U.S. Food and Drug Administration, other regulatory agencies, or the manufacturer remove the drug from the market, limit its use in a manner that affects the authorization, or communicate a patient safety issue that would affect the authorization alone or in combination with other authorizations; (iii) a combination of drugs prescribed would cause a drug interaction; or (iv) a generic or biosimilar is added to the prescription drug formulary. The bill provides that such provisions do not require a carrier to cover any benefit not otherwise covered or cover a prescription drug if the enrollee is no longer covered by a health plan on the date the prescription drug was scheduled, provided, or delivered. This bill is identical to HB 1134.

Patron - Favola

P SB118 Health insurance; coverage for doula care services. Requires health insurers, corporations providing health care subscription contracts, and health maintenance organizations whose policy, contract, or plan includes coverage for obstetrical services to provide coverage for doula care services provided by a state-certified doula. The bill requires such coverage to include coverage for at least eight visits during the antepartum or postpartum period and support during labor and delivery. The bill provides that health insurance carriers are (i) not required to pay for duplicate services actually rendered by both a state-certified doula and another health care provider and (ii) prohibited from requiring supervision, signature, or referral by any other health care provider as a condition of reimbursement for doula care services, except when those requirements are also applicable to other categories of health care providers. Such provisions of the bill are subject to a reenactment clause. The bill also requires the Health Insurance Reform Commission to consider coverage for doula care ser-

using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound.
Patron - Simonds

C HB489 Insurance; Fire Programs Fund; purposes. Provides that the portion of the Fire Programs Fund allocated to localities may be used for the additional purposes of (i) constructing, improving, or expanding fire station facilities, (ii) providing mental health resources, or (iii) hiring additional fire personnel and funding recruitment and retention programs. The bill also prohibits such funds from being used, except as provided, for the purposes of investments, operating expenses, debt repayment, taxes, or fees.
Patron - Garrett

C HB510 Surplus line broker taxes. Provides that any surplus lines broker or any person required to be licensed as one shall not be subject to the annual taxes, license taxes, or penalties under current law for any policy of insurance procured during the preceding calendar year on behalf of a commuter rail system jointly operated by the Northern Virginia Transportation Commission and the Potomac and Rappahannock Transportation District.
Patron - Cohen

C HB610 Health insurance; coverage for diabetes. Requires that each insurer providing coverage for diabetes shall include benefits for FDA-approved insulin, continuous blood glucose monitoring, and regular foot care and eye care exams in addition to equipment, supplies, and self-management training and education. The bill allows for such self-management training and education to be provided either in-person outpatient or through telemedicine. Under the bill, such coverage for self-management training and education shall include up to three outpatient visits upon an individual receiving an initial diagnosis of diabetes and up to two medically necessary visits to a qualified provider upon a significant change in the patient's symptoms or medical condition. The bill also repeals certain provisions of law related to cost-sharing for insulin and provides that the coverage required by the bill shall be exempt from any deductible or cost-sharing payment requirement. The provisions of the bill apply to insurance policies, contracts, and plans issued for delivery, reissued, extended, or amended on and after January 1, 2025.
Patron - Price

C HB864 Health insurance; coverage for therapeutic day treatment services. Requires health insurers providing health care plans to provide coverage for therapeutic day treatment services for children with serious emotional disturbances, defined in the in bill as children who have a mental illness diagnosis and have experienced functional limitations due to emotional disturbance, including experiencing a school shooting or the loss of a loved one in a school setting, over the past 12 months on a continuous or intermittent basis. Under the bill, "therapeutic day treatment services" are treatment programs that combine psychotherapeutic interventions with education and mental health and may include evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills; and individual, group, and family counseling. The bill applies to plans delivered, issued for delivery, or renewed on and after January 1, 2025.
Patron - Clark

C HB1041 Health insurance; cost-sharing; pharmacy benefits managers' compensation and duties: civil penalty. Amends provisions related to rebates provided by carriers and health benefit plans to health plan enrollees by defining "defined cost-sharing," "price protection rebates," and "pharmacy benefits management services." The bill requires that an enrollee's defined cost-sharing for each prescription drug be calculated at the point of sale based on a price that is reduced by an amount equal to at least 80 percent of all rebates received or expected to be received in connection with the dispensing or administration of the prescription drug.

The bill prohibits a pharmacy benefits manager from deriving income from pharmacy benefits management services provided to a carrier or health benefit plan except for income derived from a pharmacy benefits management fee. The bill requires the amount of any pharmacy benefits management fees to be set forth in the agreement between the pharmacy benefits manager and the carrier or health benefit plan and that such fee not be based on the acquisition cost or any other price metric of a drug; the amount of savings, rebates, or other fees charged, realized, or collected by or generated based on the activity of the pharmacy benefits manager; or the amount of premiums, deductibles, or other cost-sharing or fees charged, realized, or collected by the pharmacy benefits manager from enrollees or other persons on behalf of an enrollee. The bill requires a pharmacy benefits manager to annually certify to the State Corporation Commission that it has met certain requirements.

The bill establishes a pharmacy benefits manager duty, which includes the duties of care and good faith and fair dealing, owed to any enrollee, provider, or health benefit plan that receives pharmacy benefits management services from the pharmacy benefits manager or that furnishes, covers, receives, or is administered a unit of a prescription drug for which the pharmacy benefits manager has provided pharmacy benefits management services. The bill requires the Commission to define by regulation the scope of such duty and provides for a private cause of action for any person aggrieved by the breach of such duty.

Patron - O'Quinn

C HB1347 Health insurance; coverage for autism spectrum disorder; cost-sharing requirements prohibited for certain individuals. Prohibits a health carrier from imposing any copayment, coinsurance, or deductible for the diagnosis of autism spectrum disorder and the treatment of autism spectrum disorder for individuals who are age 18 or younger.

Patron - Srinivasan

C SB376 Health insurance; limit on cost-sharing payments for prescription drugs under certain plans. Requires each carrier that offers a health plan in either the individual or small group market to ensure that at least 50 percent of all health plans offered by the carrier, or at least one health plan if the carrier offers fewer than two health plans, in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage in the individual and small group market conform with the following: (i) a plan that offers a silver, gold, or platinum level of coverage limits a person's cost-sharing payment for prescription drugs covered under the plan to an amount that does not exceed $100 per 30-day supply of the prescription drug and (ii) a plan that offers a bronze level of coverage limits a person's cost-sharing payment for prescription drugs covered under the plan to an amount that does not exceed $150 per 30-day supply of the prescription drug. The bill provides that such limits apply at any point in the benefit design, including before and after any applicable deductible is reached. The bill requires that any plans offered to meet its requirements are (a) clearly and appropriately named to aid the consumer or plan sponsor in the plan selection process and (b) marketed in the same manner as other plans offered by the health insurance carrier. The provisions of the bill apply with

noting that a parking space is reserved for charging plug-in electric motor vehicles include the civil penalty for parking in violation of such sign. This bill was vetoed by the Governor.
Patron - Reaser

P **HB812 Special license plates; Sons of Confederate Veterans and Robert E. Lee.** Repeals authorization for the issuance of Sons of Confederate Veterans and Robert E. Lee special license plates and provides that such special license plates already in circulation will remain valid until their expiration and shall not be renewed. This bill received Governor's recommendations.
Patron - Mundon King

P **HB844 Commercial driver's licenses and commercial learner's permits; definitions; commercial driver training; drug and alcohol violations.** Conforms the definition of commercial motor vehicle to federal regulations, codifies the entry-level driver training system required by federal regulations, and removes contradictory provisions. The bill also prohibits the issuance or continued validity of commercial driver's licenses and commercial learner's permits after a drug or alcohol violation by the applicant, licensee, or permittee. The bill contains technical amendments. This bill is identical to SB 353.
Patron - Austin

P **HB845 Abandoned vehicles; owner and lienholder information.** Provides that if an abandoned vehicle has been titled in another jurisdiction, the Department of Motor Vehicles, in its search for the owner or lienholder of such vehicle, may rely on information provided by a business in possession of the abandoned vehicle that acquired such vehicle from an insurance company in connection with a total loss unresolved claim, provided that such information is obtained from a nationally recognized title database with access to such jurisdiction's records about all entities having security interest in such vehicle. The bill requires the business to defend, indemnify, and hold the Department and the Commonwealth harmless for damages and costs resulting from such reliance.
Patron - Austin

P **HB924 Transportation network companies; publishing and disclosure requirements.** Requires a transportation network company (TNC) to (i) issue an annual report to the Commissioner of the Department of Motor Vehicles containing the aggregate data regarding the average fare collected from passengers, the total time driven by TNC partners while transporting a passenger, and the total amount earned by TNC partners in connection with prearranged rides and (ii) disclose to TNC partners details about the deactivation process and provide a weekly summary that includes the total fare collected from passengers, the total amount earned, and the percentage earned by such TNC partner that week. This bill was vetoed by the Governor.
Patron - Srinivasan

P **HB925 Towing; vehicles with expired registration; civil penalty.** Requires a towing operator, defined in the bill, for a parking lot of a multifamily dwelling unit, defined in the bill, to post written notice on a vehicle providing at least 48 hours' notice to a resident prior to removing a resident's vehicle, defined in the bill, from such parking lot of the multifamily dwelling unit for an expired registration or expired vehicle inspection sticker and to provide a copy of such notice to the landlord of such multifamily dwelling unit. The bill provides that a towing operator who fails to comply with these requirements shall be required to reimburse the resident for the cost of the tow and shall be subject to a civil penalty not to exceed $100.
Patron - Shin

P **HB959 Towing violations; enforcement; fuel surcharge fee.** Authorizes localities in Planning Districts 8 and 16 to require written authorization of the owner of the property from which the vehicle is towed at the time the vehicle is being towed and regulate the monitoring practices that may be used by towing and recovery operators. Current law authorizes localities other than those in Planning Districts 8 and 16 to require written authorization of the owner of the property from which the vehicle is towed at the time the vehicle is being towed. The bill changes the penalty for certain trespass towing offenses in Planning District 8 from $150 per violation paid to the Literary Fund to 10 times the total amount charged for such removal, towing, and storage to be paid to the victim of the unlawful towing. The bill also changes the expiration date of the authorization for towing and recovery operators to charge a fuel surcharge fee of no more than $20 for each vehicle towed or removed from private property without the consent of its owner and the prohibition on local governing bodies limiting or prohibiting such fee from July 1, 2024, to July 1, 2025.
Patron - Lopez

P **HB1071 Reduction of speed limits; local authority.** Expands the current authority of any locality to reduce the speed limit to less than 25 miles per hour, but not less than 15 miles per hour, on highways within its boundaries that are located in a business district or residence district to include highways within the state highway system, provided that such reduced speed limit is indicated by lawfully placed signs. The bill authorizes a locality to restore a speed limit that has been reduced pursuant to this authority and requires the locality to notify the Commissioner of Highways of a change in speed limit. This bill incorporates HB 793. This bill received Governor's recommendations.
Patron - Carr

P **HB1073 Tow truck drivers; prohibited acts.** Prohibits tow truck drivers from driving by the scene of a wrecked or disabled vehicle for which a law-enforcement tow has been initiated by a law-enforcement agency, initiating contact with the owner or operator of such vehicle by soliciting or offering towing services, and towing such vehicle.
Patron - Carr

P **HB1080 License suspensions due to driving during a period of suspension or revocation; period of suspension.** Prohibits any license suspensions due to driving during a period of suspension or revocation from extending beyond 10 years from the date of conviction for such violation.
Patron - Carr

P **HB1082 Enforcement of certain judgments; restricted license.** Authorizes the court to order a restricted license to operate a motor vehicle to a judgment debtor who has had his driver's license suspended for failure to satisfy certain judgments.
Patron - Carr

P **HB1084 Disabled parking placards; validity; fees.** Extends from six months to 12 months the maximum duration for which the DMV may issue a temporary removable windshield placard to a person with a disability that limits or impairs his ability to walk or that creates a concern for his safety while walking. The bill also eliminates the fee for the issuance of temporary and permanent disabled parking placards and includes technical amendments.
Patron - Carr

P **HB1106 Motor vehicle dealers; independent dealer-operator recertification; exam.** Permits the recertification of independent dealer-operators by passing an examination administered by the Department of Motor Vehicles. Current law provides that such recertification requires completing one live instructor-led course and passing an examination administered by the course provider. The bill also directs the Department to collect the $50 exam fee at the time the exam is administered, transmit $48 from that fee to the Motor Vehicle Dealer Board within 15 days, and retain the remaining $2. This bill is identical to SB 452.

Patron - Wyatt

P **HB1107 Motor Vehicle Dealer Board; examination costs.** Authorizes the Motor Vehicle Dealer Board to establish the cost of an examination of licensee records, which existing law requires the licensee to pay if such examination shows a violation of law or order of the Board. The bill removes the authority of the Board to recover such costs in a court of competent jurisdiction and provides that failure to pay such examination costs may be grounds for denying, suspending, or revoking a license or certificate of dealer registration or qualification.

Patron - Wyatt

P **HB1109 Toll invoices; mail.** Authorizes the use of a trackable correspondence equivalent to certified mail for sending invoices for unpaid tolls to a vehicle owner prior to the Department of Motor Vehicles placing a registration stop on such vehicle due to unpaid tolls. Current law requires such invoices to be mailed by certified mail. This bill is identical to SB 205.

Patron - Wyatt

P **HB1110 Toll facilities; vehicle owner.** Provides that, in the context of automated toll enforcement, the exemption from the definition of "owner" for vehicle rental or vehicle leasing companies applies only if such companies meet existing requirements related to handling toll invoices on rented or leased vehicles.

Patron - Wyatt

P **HB1112 Auto recyclers; database search.** Clarifies the databases to be searched by the Department of Motor Vehicles upon notification by an auto recycler that he possesses a motor vehicle to be demolished but does not possess a certificate of title, salvage certificate, or nonrepairable certificate for such motor vehicle. The bill has a delayed effective date of July 1, 2025, and is identical to SB 545.

Patron - Wyatt

P **HB1163 Department of Motor Vehicles; medical review.** Changes the standard for being denied a driver's license or having a driver's license reviewed or revoked for medical reasons by removing language regarding the presence of a disability or disease and requiring the existence of an impairment that will prevent the driver from exercising reasonable and ordinary control over a motor vehicle or drive a motor vehicle safely.

Patron - Sickles

P **HB1224 Department of Motor Vehicles; fees.** Reduces the fee for the issuance of an original, duplicate, reissue, or renewal special identification card without a photograph from $10 per year with a $20 minimum fee to $2 per year with a $10 minimum fee. This bill is identical to SB 151.

Patron - Runion

P **HB1287 Towing companies; local authority.** Clarifies that the provisions of existing law authorizing localities in Planning District 8 to require towing companies that tow from the county, city, or town to a storage or release location outside of the locality to obtain a permit to do so do not restrict or modify the authority of the locality to require that towing companies that tow and store or release vehicles within the county, city, or town to obtain from the locality a permit to do so.

Patron - McClure

P **HB1324 Issuance of restricted driver's license for multiple convictions of driving while intoxicated; completion of specialty dockets.** Provides that a person whose driver's license has been revoked for multiple convictions of driving while intoxicated may file a petition for the issuance of a restricted driver's license without having to wait for the expiration of three years from the date of his last conviction, regardless of the date of such conviction, when such person's last conviction resulted from a final order being entered by a court after the successful completion of a Veterans Treatment Court Program, behavioral health docket, or other specialty docket. This bill is identical to SB 6.

Patron - Fowler

P **HB1362 School bus video-monitoring system; citations.** Prohibits a contract between a private vendor and a school division for the operation of school bus video-monitoring systems to capture passing stopped school bus violations from requiring a minimum quota of violations captured or citations issued for the video-monitoring system to be deployed.

Patron - Maldonado

P **HB1409 Crash reports; contracted service providers.** Authorizes law-enforcement agencies to utilize a contracted service provider to forward crash reports electronically to the Department of Motor Vehicles and manage or disseminate copies of certain crash reports as authorized by law. The bill authorizes the release of nonpersonally identifiable vehicle information from crash reports to a contracted service provider. This bill is identical to SB 732.

Patron - Reid

P **HB1419 Electronic sales by dealers; titling.** Authorizes certain motor vehicle dealers to choose to sell a motor vehicle electronically by obtaining a title in the dealer's name for resale. This bill has a contingent effective date of the earlier of (i) July 1, 2025, or (ii) receipt of proper notification that a secure power of attorney prescribed by federal law and in a form approved by the Department of Motor Vehicles is available to motor vehicle dealers to be electronically signed by a purchaser.

Patron - Kilgore

P **HB1454 Limited-duration licenses and driver privilege cards and permits; expiration.** Extends the validity of limited-duration licenses, driver privilege cards and permits, and identification privilege cards, other than REAL ID credentials and commercial driver's licenses and permits, to a period of time consistent with the validity of driver's licenses, which, under current law, is a period not to exceed eight years or, for a person age 75 or older, a period not to exceed five years, and permits and special identification cards. The bill directs the Department of Motor Vehicles to implement the extended validity periods for such documents upon reissuance. This bill is identical to SB 246. This bill was vetoed by the Governor.

Patron - Lopez

property open to the public; any industrial establishment providing parking space for customers, patrons, or employees; and any highway under construction or not yet open to the public.

The bill allows, in Planning District 8, a law-enforcement officer to stop a passenger car he determines is emitting exhaust system noise in excess of such limit and issue a notice of an administrative fee of $250 to be assessed at the time of the vehicle's next registration renewal and establishes a process for inspecting such vehicle.

The bill has a contingent effective date of January 1, 2025, provided that the Department of Environmental Quality has received the necessary funding to supply the necessary equipment for such vehicle exhaust system inspections to inspection stations. The bill sunsets on July 1, 2027.

Patron - Watts

C **SB198** **License plates; collector motor vehicles; penalty.** Creates license plates for collector motor vehicles, defined in the bill, which the Commissioner of the Department of Motor Vehicles shall issue to any applicant who owns or has regular use of another passenger car, autocycle, or motorcycle and who owns at least a total of three collector motor vehicles. The bill designates the fee for such plates and registration as $50, specifies that the collector motor vehicles shall not be used for general transportation purposes and may only be used (i) for participation in shows, parades, charitable functions, and historical exhibitions for display, maintenance, and preservation; (ii) on the highways of the Commonwealth for the purpose of testing their operation or selling the vehicle, obtaining repairs or maintenance, transportation to and from events, and for occasional pleasure driving not exceeding 250 miles from the residence of the owner; and (iii) to carry or transport passengers and personal effects. The bill also prohibits such vehicles from being registered as antique vehicles or military surplus motor vehicles. Finally, the bill makes it a Class 4 misdemeanor to violate any provision relating to the registration of collector motor vehicles.

Patron - Diggs

C **SB226** **Department of Motor Vehicles; highway use fee; tiered flat rate system; work group; report.** Directs the Department of Motor Vehicles to convene a work group to determine the feasibility of implementing a tiered flat rate system to accurately determine the correct amount of highway use fee to be charged at the point of sale of a motor vehicle. The bill directs the work group to complete its work and report its findings and recommendations to the Chairs of the Senate and House Committees on Transportation no later than November 15, 2024.

Patron - Hackworth

C **SB349** **Vehicle inspections; new motor vehicles.** Extends the timeframe following the first inspection of a new motor vehicle in which such vehicle must be inspected from 12 months after the first inspection to either 36 months after the first inspection or within such time as such new motor vehicle reaches a mileage of 36,000 miles. The bill provides that the inspection approval sticker provided by the Department of State Police for such new motor vehicle shall designate its validity period and directs the Department to develop, create, and distribute such new stickers.

Patron - Reeves

C **SB714** **Vehicle exhaust systems; inspection and administrative fee.** Prohibits passenger vehicle exhaust systems from emitting noise in excess of 95 decibels in Planning District 8 on a highway; any driveway or premises of a church, school, recreational facility, or business; any governmental property open to the public; any industrial establishment providing parking space for customers, patrons, or employees; and any highway under construction or not yet open to the public.

The bill allows, in Planning District 8, a law-enforcement officer to stop a passenger vehicle he determines is emitting exhaust system noise in excess of such limit and issue a notice of an administrative fee of $250 to be assessed at the time of the vehicle's next registration renewal and establishes a process for inspecting such vehicle.

The bill has a contingent effective date of January 1, 2025, provided that the Department of Environmental Quality has received the necessary funding to supply the necessary equipment for such vehicle exhaust system inspections to inspection stations. The bill sunsets on July 1, 2027.

Patron - Marsden

Notaries and Out-of-State Commissioners

Passed

P **HB986** **Notaries; fees.** Raises from $5 to $10 the amount a notary may charge for taking and certifying the acknowledgment of any writing, or administering and certifying an oath, or certifying affidavits and depositions of witnesses.

Patron - Tran

P **HB1372** **Notarial acts; knowledge-based authentication assessment; requirements.** Adds a knowledge-based authentication assessment to the methods by which a notary public may obtain satisfactory evidence of identity of an individual. As defined in the bill, a knowledge-based authentication assessment requires a principal to take a quiz composed of at least five questions related to the principal's personal history or identity and to score at least 80 percent on such quiz. The bill provides that if the principal fails to achieve a score of at least 80 percent, he may attempt up to two additional quizzes within 48 hours following the first failed quiz. The bill also provides that no notarial act shall be invalidated solely based on the failure of a notary public to perform a duty or meet a requirement as required by law; however, the validity of a notarial act shall not prohibit an aggrieved person from invalidating a record or transaction or from seeking other remedies as allowed by law. The bill provides that these provisions shall apply retroactively to any notarial act that was performed before July 1, 2024. This bill received Governor's recommendations.

Patron - Simon

P **SB8** **Notary public or electronic notary public; application for recommission.** Removes the requirement that a person applying for recommission as a notary public or electronic notary public include in his application an applicant oath, provided that such person is in good standing as a notary public or electronic notary public, is not subject to any investigation or proceeding, and has never been removed from office. Under current law, persons applying for recommission are required to include such oath.

Patron - Reeves

Carried Over

C **HB988** **Behavioral health services in correctional facilities; report.** Requires the Department of Corrections to report to the General Assembly and the Governor on or before October 1 of each year certain population statistics regarding the provision of behavioral health services to persons incarcerated in state correctional facilities. The bill also requires local correctional facilities to report to the State Board of Local and Regional Jails on or before October 1 of each year certain population statistics regarding the provision of behavioral health services to persons incarcerated in local correctional facilities and for the Board to report such statistics to the General Assembly and the Governor on or before December 1 of each year.

Patron - Seibold

C **HB1121** **Department of Corrections; online educational courses.** Requires the Director of the Department of Corrections to establish, develop, and implement an educational program with the Online Virginia Network Authority for the purposes of providing a means for prisoners to earn degrees and postsecondary education credentials through accessing online degree and credential programs that are offered by George Mason University, Old Dominion University, James Madison University, and comprehensive community colleges.

Patron - Carr

C **HB1405** **Prisoners; Department of Corrections-issued and jailer-issued identification.** Provides that the Department of Corrections shall establish a procedure for securing a government-issued identification card, birth certificate, or Social Security card through the Department of Motor Vehicles and that the Department of Motor Vehicles shall expedite the processing of an application submitted by a prisoner for such government-issued identification card and the issuance of such identification. The bill also requires the Department of Corrections, in coordination with the State Board of Local and Regional Jails, the Department of Motor Vehicles, and the State Registrar of Vital Records, to (i) review the processes involved in assisting a prisoner in applying for and obtaining a government-issued identification card, birth certificate, or Social Security card; (ii) identify any obstacles that may interfere with a prisoner obtaining such identification or documents prior to such prisoner's release or discharge; and (iii) issue a report of its findings and recommendations to the General Assembly no later than November 1, 2024.

Patron - Cousins

C **SB378** **State correctional facilities; telephone calls and communication services.** Requires the Department of Corrections to provide telephone systems and web-based or electronic communications systems free of charge to any person, whether such person is initiating or receiving the communication. The bill also requires that a minimum ratio of one telephone per every 10 inmates be available within each housing unit at each correctional facility and that the maximum number of telephone numbers permitted on an approved call list must be no fewer than 20.

Patron - Boysko

Professions and Occupations

Passed

P **HB42** **Civil immunity; dentists and dental hygienists; mental health treatment for health care professionals; reporting requirements.** Adds dentists and dental hygienists to the list of providers who are immune from civil liability for any act done or made in performance of his duties while serving as a member of or consultant to an entity that functions primarily to review, evaluate, or make recommendations on a professional program to address issues related to career fatigue and wellness in health care professionals. The bill also extends civil immunity to certain providers for any act done or made in performance of his duties while serving as a member of or consultant to an entity that functions primarily to arrange for or provide outpatient health care for health care professionals. The bill also revises the Board of Medicine reporting requirements when a health care professional is admitted for mental health treatment. Under the bill, if a health care professional is voluntarily admitted to a health care institution for treatment of a substance abuse or psychiatric illness and is no longer believed to be a danger within 30 days then no report will be made to the Board of Medicine. This bill is identical to SB 629.

Patron - Hope

P **HB120** **Department of Professional and Occupational Regulation; Department of Health Professions; certain suspensions not considered disciplinary action.** Prohibits any board of the Department of Professional and Occupational Regulation or the Department of Health Professions issuing a suspension upon any regulant of such board pursuant to such regulant's having submitted a check, money draft, or similar instrument for payment of a fee required by statute or regulation that is not honored by the bank or financial institution named from considering or describing such suspension as a disciplinary action.

Patron - Sullivan

VAC here.

P **HB188** **Advance Health Care Planning Registry; amendment of regulations.** Amends the list of documents that may be submitted to the Advance Health Care Directive Registry to include any other document that supports advance health care planning. The bill also changes the name of the Advance Health Care Directive Registry to the Advance Health Care Planning Registry. The bill directs the Department of Health to amend certain Advance Health Care Planning Registry regulations. This bill is identical to SB 154.

Patron - Hope

P **HB214** **Common interest communities; residents providing certain services exemption.** Provides that a resident of a common interest community association who provides bookkeeping, billing, or recordkeeping services for such community for compensation shall be presumed to be an independent contractor. The bill also exempts common interest community associations from the definition of "employer" where a resident provides such services. This bill received Governor's recommendations.

Patron - Watts

P **HB225** **Dentist and Dental Hygienist Compact.** Authorizes Virginia to become a signatory to the Dentist and Dental Hygienist Compact. The Compact increases public access to dental services by permitting eligible licensed dentists and dental hygienists to practice in Compact participating

Wildlife, Inland Fisheries and Boating

Passed

P **HB288 Stationary blinds for waterfowl; providing location of blinds to Department of Wildlife Resources.** Requires a person that is obtaining a waterfowl blind license, at the time of the transaction, to provide the unique location of each stationary waterfowl blind to the Department of Wildlife Resources, identified as standardized latitude and longitude coordinates, using the decimal degrees format with a minimum of five digit precision. The bill further requires the Department to publish such coordinates by November 1 of each year, excluding any customer personal information, on its website in a searchable, publicly accessible, and conspicuous manner. The bill has a delayed effective date of January 1, 2025.
Patron - Wiley

P **HB879 Conveyance of easement.** Authorizes the Department of Wildlife Resources to grant and convey an easement and right-of-way at Land's End Wildlife Management Area to Joseph C. Frank III, Betty J. Frank, Jacob C. Ackerman, and Crystal F. Ackerman. The easement will allow ingress and egress from State Route 625 (Salem Church Road) to the grantees' properties.
Patron - Kent

P **HB1025 Claiming a deer, bear, turkey, or elk struck by motor vehicle.** Allows any deer, bear, turkey, or elk that appears to have been killed in a collision with a motor vehicle to be claimed by and awarded to any person. Current law allows a deer or bear to only be claimed by and awarded to the driver of a motor vehicle who collides with such animal.
Patron - Wilt

P **HB1053 Destruction and disposal of abandoned watercraft by localities and state agencies.** Allows localities and state agencies to apply, under certain conditions, to the Department of Wildlife Resources for an authorization to destroy and dispose of an abandoned watercraft.
Patron - Knight

P **HB1058 Department of Wildlife Resources; singular license for waterfowl blinds in Chesapeake Bay Public Access Authorities.** Requires the Department of Wildlife Resources to develop a singular license for all riparian stationary blinds issued to the Middle Peninsula Chesapeake Bay Public Access Authority and the Northern Neck Chesapeake Bay Public Access Authority and to develop a fee schedule for such license.
Patron - Hodges

Failed

F **HB709 Department of Wildlife Resources; killing of deer, elk, or bear damaging fruit trees, crops, livestock, or personal property.** Allows the owner or lessee of lands upon which damage to fruit trees, crops, livestock, or personal property utilized for commercial agricultural production has occurred to solicit the opinion of a district biologist in a neighboring district when, after an assessment by the district biologist for the lands upon which such damage has occurred, authorization to kill an animal is not granted by the Director of the Department of Wildlife Resources or his designee.
Patron - Webert

F **HB789 Special lifetime hunting and fishing license; military veterans.** Allows any resident of the Commonwealth who is a veteran of the United States Armed Forces or the National Guard and Reserve who applies for the resident lifetime hunting license or the resident lifetime fishing license to receive such license. The cost for such license is set for one of the following fees based on age: age 50 or younger, $200; age 51 through 55, $150; age 56 through 60, $100; age 61 through 64, $50; and age 65 or older, $10.
Patron - Ennis

F **HB999 Hunting within certain areas of Indian River prohibited; City of Chesapeake.** Makes it unlawful for a person to take, attempt to take, or pursue wildlife within the Indian River from its confluence with the eastern branch of the Elizabeth River to its southern terminus at Military Highway in the City of Chesapeake, except that fishing is permitted in such area.
Patron - Anthony

F **HB1406 Fishing license requirements; exemptions; free fishing days.** Increases from three to six the maximum number of days that the Board of Wildlife Resources may designate as free fishing days for a person to fish in any inland waters of the Commonwealth without a fishing license.
Patron - Fowler

F **SB455 Wildlife Corridor Grant Fund established; report.** Establishes the Wildlife Corridor Grant Fund to provide grants for projects that conserve or enhance wildlife corridors prioritized by the Wildlife Corridor Action Plan and associated wildlife crossing infrastructure projects. The bill directs the Director of Wildlife Resources to administer the Fund and to consult with the Department of Conservation and Recreation, the Department of Forestry, the Department of Transportation, and the Department of Wildlife Resources on disbursing moneys from the Fund. The bill also requires the Director to submit a report to the General Assembly by November 1 of each odd-numbered year concerning funding of the Fund, the awarding of grants from the Fund, and the progress of projects funded by the Fund, including data on the use of project infrastructure by wildlife.
Patron - Marsden

Wills, Trusts, and Fiduciaries

Passed

P **HB115 Guardians and conservators; order of appointment and certificate of qualification; annual report.** Requires a petitioner to file with a petition for the appointment of a guardian, a conservator, or both a cover sheet on a form prepared by the Office of the Executive Secretary of the Supreme Court of Virginia. The bill requires a guardian to file an initial annual report reflecting the first four months of guardianship since qualification within six months of the date of qualification and to file the second and each subsequent annual report for each succeeding 12-month period within four months from the last day of the last 12-month period covered by the previous annual report. The bill also specifies which documents the clerk shall forward to certain entities upon the qualification of a guardian or conservator. This bill is a recom-

 RSM: Link to form in SB290, below.

mendation of the Judicial Council of Virginia and is identical to SB 290.
Patron - Sullivan

P **HB332** **Termination of trust; notice requirements.** Provides that a trustee seeking to terminate a trust consisting of trust property that has a total value of less than $100,000 may do so without a court order, provided that the trustee sends notice, as specified in the bill, to any qualified beneficiaries or cotrustees. This bill is identical to SB 63.
Patron - Jones

P **HB336** **Certain powers of attorney; transfer on death deeds.** Provides that an agent under a power of attorney shall not have the authority to create, change, or revoke a transfer on death deed unless specifically granted the power to create or change a beneficiary designation as otherwise provided by law. This bill is identical to SB 471.
Patron - Jones

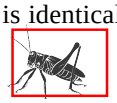
P **HB678** **Trustees; settlement of accounts; notice and statements to beneficiaries; requirements.** Provides that the beneficiary of a trust shall be deemed to have released a trustee and ratified all actions of a trustee for the administration of a trust if, when the trust terminates or the trustee ceases to serve, the trustee sends the beneficiary notice and the beneficiary does not object within 60 days after the trustee sent such notice. The bill also requires the trustee to provide to the beneficiary certain financial information related to the trust. This bill is identical to SB 566.
Patron - Leftwich

P **HB786** **Guardianship and conservatorship; restoration of capacity or modification or termination of order; informal written communication.** Allows a person subject to a guardianship or conservatorship who is not represented by counsel to initiate the process to be restored to capacity or have such guardianship or conservatorship modified or terminated by sending informal written communication to the court, in lieu of the petition requirement specified under current law. This bill received Governor's recommendations.
Patron - Hope

P **SB63** **Termination of trust; notice requirements.** Provides that a trustee seeking to terminate a trust consisting of trust property that has a total value of less than $100,000 may do so without a court order, provided that the trustee sends notice, as specified in the bill, to any qualified beneficiaries or cotrustees. This bill is identical to HB 332.
Patron - McDougle

P **SB102** **Wills and trusts; tangible personal property; nonexoneration.** Provides that if a trust instrument that was revocable, as defined in relevant law, immediately before the settlor's death refers to a written statement or list of items of tangible personal property and their intended recipients with reasonable certainty and is signed by the settlor, such written statement or list shall be given the effect of a specific bequest although it does not satisfy the requirements for a trust instrument. The bill also provides that real or personal property that is the subject of a specific devise or bequest in a trust instrument that was revocable immediately before the settlor's death shall be passed without the right of exoneration. Under current law, the provisions that govern separate writing identifying recipients of tangible personal property apply only to wills, and the provisions that govern the nonexoneration of a specific devise or bequest of real or personal property apply only to wills and transfer on death deeds.
Patron - Sturtevant

P **SB290** **Guardians and conservators; order of appointment and certificate of qualification; annual report.** Requires a petitioner to file with a petition for the appointment of a guardian, a conservator, or both a cover sheet on a form prepared by the Office of the Executive Secretary of the Supreme Court of Virginia. The bill requires a guardian to file an initial annual report reflecting the first four months of guardianship since qualification within six months of the date of qualification and to file the second and each subsequent annual report for each succeeding 12-month period within four months from the last day of the last 12-month period covered by the previous annual report. The bill also specifies which documents the clerk shall forward to certain entities upon the qualification of a guardian or conservator. This bill is a recommendation of the Judicial Council of Virginia and is identical to HB 115.
Patron - Roem



P **SB291** **Department for Aging and Rehabilitative Services; training; powers and duties of guardian; annual reports by guardians; information required.** Directs the Department for Aging and Rehabilitative Services to develop and provide training for court-appointed guardians by July 1, 2025. The bill requires a court-appointed guardian and any skilled professional retained by such guardian to perform guardianship duties to complete the initial training developed by the Department within four months after the date of qualification of such guardian. Under the bill, guardians appointed prior to July 1, 2025, must complete such training by January 1, 2027. The bill further requires a guardian to include in his annual report to the local department of social services a statement as to whether such training has been completed.
Patron - Roem

P **SB292** **Guardianship and conservatorship; report of guardian ad litem.** Adds to the considerations regarding the suitability and propriety of a prospective guardian or conservator that a guardian ad litem is required to address in his report to the court following a petition for guardianship or conservatorship. The bill provides that the guardian ad litem shall consider the prospective guardian's or conservator's work as a professional guardian, including whether the person does so on a full-time basis, the prospective guardian's or conservator's expected capacity as a guardian, and whether the prospective guardian or conservator is named as a perpetrator in any substantiated adult protective services complaint involving the respondent following allegations of abuse or neglect.
Patron - Roem

P **SB471** **Certain powers of attorney; transfer on death deeds.** Provides that an agent under a power of attorney shall not have the authority to create, change, or revoke a transfer on death deed unless specifically granted the power to create or change a beneficiary designation as otherwise provided by law. This bill is identical to HB 336.
Patron - Obenshain

P **SB566** **Trustees; settlement of accounts; notice and statements to beneficiaries; requirements.** Provides that the beneficiary of a trust shall be deemed to have released a trustee and ratified all actions of a trustee for the administration of a trust if, when the trust terminates or the trustee ceases to serve, the trustee sends the beneficiary notice and the beneficiary does not object within 60 days after the trustee sent such notice. The bill also requires the trustee to provide to the beneficiary certain financial information related to the trust. This bill is identical to HB 678.
Patron - Deeds

Failed

F **HB210** **Electronic execution of estate planning documents; Uniform Electronic Wills Act.** Permits trusts, advance medical directives, and refusals to make anatomical gifts to be signed and notarized, as appropriate, by electronic means. The bill also codifies the Uniform Electronic Wills Act, which permits a testator to execute a will by electronic means. The Act requires that the will be signed by two witnesses who are in the physical or electronic presence of the testator and acknowledged by the testator and attesting witnesses in the physical or electronic presence of a notary public.

Patron - Martinez

Carried Over

C **HB512** **Judicial Council of Virginia; work group to study conservatorship; report.** Directs the Judicial Council of Virginia to convene a work group of relevant stakeholders to study issues relating to conservatorship in the Commonwealth and to develop recommendations for a best practices model. The bill requires the work group to submit its findings and recommendations by November 1, 2024, to the Chairmen of the House Committee for Courts of Justice and the Senate Committee on the Judiciary.

Patron - Cohen

C **HB1013** **Uniform Electronic Estate Planning Documents Act.** Permits electronic nontestamentary estate planning documents, defined in the bill as certain enumerated records relating to estate planning that are readable as text at the time of signing and are not wills or contained in wills, to be signed and notarized, as appropriate, by electronic means. The bill provides that such electronic nontestamentary estate planning documents shall not be denied legal effect or enforceability or excluded as evidence in a proceeding solely because such documents are in electronic form. The bill also allows for the electronic presence, as that term is defined in the bill, of any witness who is otherwise required by law to be in the physical presence of the person signing the nontestamentary estate planning document.

Patron - Laufer

C **SB293** **Guardianship and conservatorship; duties and powers of guardian and conservator; self-dealing prohibited.** Provides that a guardian and conservator shall avoid all conflicts of interest and self-dealing, including all appearances of conflicts of interest and self-dealing, when addressing the needs of the incapacitated person to whom the guardian or conservator owes a fiduciary duty. The bill provides that a conflict of interest arises when the guardian or conservator has a personal or agency interest that can be perceived as self-serving or adverse to the position or best interest of the incapacitated person, and self-dealing arises when the guardian or conservator seeks to take advantage of his position as guardian or conservator and acts for his own interests rather than for the interests of the incapacitated person. The bill further provides that any sale or transaction that constitutes self-dealing shall be voidable by the court.

Patron - Roem

Workers' Compensation

Passed

P **HB205** **Workers' compensation; prompt payment; limitation on claims.** Prohibits an employer or workers' compensation carrier from seeking recovery of a payment made to a health care provider for health care services rendered to a claimant unless such recovery is sought less than one year from the date payment was made to the health care provider. Under current law, such prohibition only applies to services rendered after July 1, 2014.

The bill also prohibits a health care provider from submitting a claim to the Virginia Workers' Compensation Commission contesting the sufficiency of payment for health care services rendered to a claimant unless such claim is filed within one year of the date the last payment is received by the health care provider. Under current law, such prohibition only applies to services rendered after July 1, 2014.

Patron - Simonds

P **HB974** **Workers' compensation; presumption that certain injuries arose out of employment.** Provides that in any claim for workers' compensation, where the employee suffers an unexplained fall in the course of employment, such employee may satisfy the burden of proof by circumstantial evidence, testimony of others, other evidence, or any combination thereof. This bill was vetoed by the Governor.

Patron - Keys-Gamarra

P **HB1418** **Administrative Process Act; rules of the Virginia Workers' Compensation Commission.** Exempts certain rules of the Virginia Workers' Compensation Commission from the requirements of the Administrative Process Act, provided that the Commission provides an opportunity for public comment on the rules prior to adoption.

Patron - Kilgore

P **SB241** **Workers' compensation; notice of right to dispute claim.** Requires that when an employee's workers' compensation claim is denied, an employer or insurer shall include in its letter denying benefits a notice that the employee has a right to dispute the claim denial through the Virginia Workers' Compensation Commission.

Patron - McPike

Failed

F **HB1300** **"Occupational disease" definition.** Clarifies that for the purpose of worker's compensation claims, an "occupational disease" does not include certain physical conditions resulting from repetitive and sustained physical stressors.

Patron - Cordoza

Carried Over

C **HB68** **Workers' compensation; post-traumatic stress disorder incurred by dispatchers.** Allows dispatchers, as defined in the bill, to claim workers' compensation benefits relating to post-traumatic stress disorder under the Virginia Workers' Compensation Act. Currently, only law-enforcement officers and firefighters may claim such benefits.

Patron - Bulova

F **HJ19** **Constitutional amendment (first reference); Governor's term of office.** Permits a Governor elected in 2029 and thereafter to succeed himself in office. The amendment allows two four-year terms (either in succession or not in succession) but prohibits election to a third term. Service for more than two years of a partial term counts as service for one term.

Patron - Garrett

F **HJ58** **Constitutional amendment (first reference); tax and finance; exempt property; affordable housing tax exemption.** Provides that the General Assembly may by general law authorize the governing body of any county, city, town, or regional government to provide for the exemption from local real property taxation, or a portion thereof, within such restrictions and upon such conditions as may be prescribed, of real estate owned and occupied by persons of low income. Such general law shall require that (i) the real property is a single family habitation and has been owned and continuously occupied as the sole dwelling of the owner of such real property for a prescribed minimum number of years, (ii) the assessment on the property has increased by a prescribed percentage or more from the previous year or over a number of previous years, and (iii) the taxes on such property are current or the owner of such property has entered into a plan for payment of any delinquent taxes and shall establish the annual household income limits to qualify for such exemption.

Patron - Carr

Carried Over

C **HJ1** **Constitutional amendment (first reference); fundamental right to reproductive freedom.** Provides that every individual has the fundamental right to reproductive freedom and that the right to make and effectuate one's own decisions about all matters related to one's pregnancy cannot be denied, burdened, or otherwise infringed upon by the Commonwealth, unless justified by a compelling state interest and achieved by the least restrictive means. The amendment prohibits the Commonwealth from penalizing, prosecuting, or otherwise taking adverse action against an individual for exercising the individual's right to reproductive freedom or for aiding another individual in the exercise of such right, unless justified by a compelling state interest.

Patron - Herring

C **HJ2** **Constitutional amendment (first reference); qualifications of voters; right to vote; persons not entitled to vote.** Provides that every person who meets the qualifications of voters set forth in the Constitution of Virginia shall have the fundamental right to vote in the Commonwealth and that such right shall not be abridged by law, except for persons who have been convicted of a felony and persons who have been adjudicated to lack the capacity to understand the act of voting. A person who has been convicted of a felony shall not be entitled to vote during any period of incarceration for such felony conviction, but upon release from incarceration for that felony conviction and without further action required of him, such person shall be invested with all political rights, including the right to vote. Currently, in order to be qualified to vote a person convicted of a felony must have his civil rights restored by the Governor or other appropriate authority. The amendment also provides that a person adjudicated by a court of competent jurisdiction as lacking the capacity to understand the act of voting shall not be entitled to vote during this period of incapacity until his capacity has been reestablished as prescribed by law. Currently, the Constitution of Virginia provides that a person who has been adjudicated to be mentally incompetent is not qualified to vote until his competency is reestablished.

Patron - Bennett-Parker

C **HJ9** **Constitutional amendment (first reference); marriage between two individuals; repeal of same-sex marriage prohibition; affirmative right to marry.** Repeals the constitutional provision defining marriage as only a union between one man and one woman as well as the related provisions that are no longer valid as a result of the United States Supreme Court decision in *Obergefell v. Hodges*, 576 U.S. 644 (2015). The amendment provides that the right to marry is a fundamental right inherent in the liberty of persons and prohibits the Commonwealth and its political subdivisions from denying the issuance of a marriage license to two parties contemplating a lawful marriage on the basis of the sex, gender, or race of such parties. The Commonwealth and its political subdivisions are required to recognize any lawful marriage between two parties and to treat such marriages equally under the law, regardless of the sex, gender, or race of such parties. The amendment provides that religious organizations and clergy acting in their religious capacity have the right to refuse to perform any marriage.

Patron - Sickles

C **SJ1** **Constitutional amendment (first reference); fundamental right to reproductive freedom.** Provides that every individual has the fundamental right to reproductive freedom and that the right to make and effectuate one's own decisions about all matters related to one's pregnancy cannot be denied, burdened, or otherwise infringed upon by the Commonwealth, unless justified by a compelling state interest and achieved by the least restrictive means. The amendment prohibits the Commonwealth from penalizing, prosecuting, or otherwise taking adverse action against an individual for exercising the individual's right to reproductive freedom or for aiding another individual in the exercise of such right, unless justified by a compelling state interest.

Patron - Boysko

C **SJ2** **Constitutional amendment (first reference); qualifications of voters; right to vote; persons not entitled to vote.** Provides that every person who meets the qualifications of voters set forth in the Constitution of Virginia shall have the fundamental right to vote in the Commonwealth and that such right shall not be abridged by law, except for persons who have been convicted of a felony and persons who have been adjudicated to lack the capacity to understand the act of voting. A person who has been convicted of a felony shall not be entitled to vote during any period of incarceration for such felony conviction, but upon release from incarceration for that felony conviction and without further action required of him, such person shall be invested with all political rights, including the right to vote. Currently, in order to be qualified to vote a person convicted of a felony must have his civil rights restored by the Governor or other appropriate authority. The amendment also provides that a person adjudicated by a court of competent jurisdiction as lacking the capacity to understand the act of voting shall not be entitled to vote during this period of incapacity until his capacity has been reestablished as prescribed by law. Currently, the Constitution of Virginia provides that a person who has been adjudicated to be mentally incompetent is not qualified to vote until his competency is reestablished.

Patron - Locke

C **SJ10** **Constitutional amendments (first reference);executive branch of government; Lieutenant Governor and Attorney General; term limits.** Prohibits any person from being eligible to be elected to more than two terms as Lieutenant Governor or Attorney General. The amendments

Appendix B: 2024 SESSION HIGHLIGHTS

The *2024 Session Highlights* summarizes significant legislation considered by the 2024 Session of the General Assembly as selected by the staff of the Virginia Division of Legislative Services. The brief overview of the 2024 Session covers legislative actions through sine die on Saturday, March 9, 2024. Bills are differentiated as Passed, Failed, or Carried Over. Passed bills are subject to review and veto by the Governor; thus, some of the bills listed as passed in this volume may be amended and some may not become law.

Agriculture/Natural Resources

Passed

HB 47/SB 306 Invasive plant species; retail sales; civil penalty. Requires, for the retail sale of any invasive plant species for outdoor use on a list established by the Department of Conservation and Recreation, a retail establishment to post in a conspicuous manner on the property located in proximity to each invasive plant display signage identifying such plant as invasive, educating consumers regarding invasive plant species, and encouraging consumers to ask about alternatives. The bill requires the Commissioner of Agriculture and Consumer Services to designate the format, size, and content of such signage no later than October 1, 2024, and requires the Commissioner to issue a stop sale order and mark or tag a plant in a conspicuous manner when an invasive plant is for sale at a retail establishment without appropriate signage. In such case, the bill requires the Commissioner to give written notice of a finding made to the owner, tenant, or person in charge of such retail establishment and requires the stop sale order issued to remain in effect until the required signage is posted. Any retail establishment that violates the provisions of the bill is subject to a civil penalty not to exceed $500.

HB 892/SB 616 Department of Agriculture and Consumer Services; Department of Forestry; Office of Farmland Preservation transferred. Transfers from the Department of Agriculture and Consumer Services to the Department of Forestry the Office of Farmland Preservation and its powers and duties and reporting requirements, the Virginia Farm Link Program, the Century Farm Program, and the Virginia Farmland and Forestland Preservation Fund. The bill renames the Office as the Office of Working Lands

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Preservation. The bill makes technical amendments to effectuate the transfer and requires the Department of Environmental Quality to report to the Department of Forestry by July 1 of each year certain enumerated information about nonpoint source nutrient credits certified in the previous year that involve land use conversion.

HB 1085/SB 243 Department of Environmental Quality; Department of Health; PFAS; identification; monitoring; PFAS Expert Advisory Council established; report. Requires, for every public water system, as defined in the bill, the Department of Health (VDH) to assist the Department of Environmental Quality (the Department) by transferring to the Department quarterly all validated monitoring results available to VDH that indicate PFAS maximum containment level, as defined in the bill, exceedances. In such circumstances, the bill provides that the Department is required to develop and implement a plan to prioritize and conduct PFAS assessments for identifying significant sources of PFAS in such public water system's raw water source or sources. The bill requires any facility, if deemed by the Department to be a potentially significant source of PFAS in the public water system's raw water source, (i) to perform and promptly report the results of quarterly discharge monitoring for one year and (ii) to report to the Department, within 90 days after being directed by the Department, its manufacture or use of PFAS. The bill establishes a PFAS Expert Advisory Committee to assist the Department and VDH in its PFAS-related efforts and requires the Committee to meet at least two times per year through June 30, 2027. The bill requires the Department to annually report certain information to the Governor and the General Assembly by October 1.

HB 1531 Cruelty to elephants; pain-inflicting training tools prohibited; actions for attachment; civil penalty. Prohibits using devices such as a bullhook, axe handle, or block and tackle or engaging in certain practices in order to discipline, train, or control the behavior of an elephant. The bill provides that any person who uses such devices or engages in certain practices that inflict fear or pain on or cause physical injury to an elephant is subject to a civil penalty not to exceed $2,500 for the first offense and not to exceed $5,000 for subsequent violations. Finally, the bill provides that an action in equity may be brought to request an attachment for any devices prohibited by the bill against a person violating the provisions of the bill.

Alcoholic Beverages and Cannabis

Passed

HB 688/SB 635 Alcoholic beverage control; sale and delivery of mixed beverages and pre-mixed wine for off-premises consumption; third-party delivery license; sunset; repeal. Repeals the July 1, 2024, sunset on provisions that allow (i) distillers that have been appointed as agents of the Board of Directors of the Virginia Alcoholic Beverage Control Authority, mixed beverage restaurant licensees, and limited mixed beverage restaurant licensees to sell mixed beverages for off-premises consumption and (ii) farm winery licensees to sell pre-mixed wine for off-premises consumption. The bill also repeals, effective July 1, 2026, third-party delivery licenses. The bill requires the Authority to convene a work group to review third-party delivery licenses and report its findings and recommendations to the Chairmen of the House Committee on General Laws and the Senate Committee on Rehabilitation and Social Services by November 15, 2024.

HB 698/SB 448 Cannabis control; retail market; penalties. Establishes a framework for the creation of a retail marijuana market in the Commonwealth, to be administered by the Virginia Cannabis Control Authority. The bill allows the Authority to begin issuing all marijuana licenses on September 1, 2024, but provides that no retail sales may occur prior to May 1, 2025.

Failed

SB 168 Alcoholic beverage control; food-to-beverage ratio. Reduces the current 45 percent food-to-beverage ratio for certain mixed beverage licensees.

The bill requires that a mixed beverage restaurant, caterer's, or limited caterer's licensee meet or exceed the following: (i) for such licensees with monthly food sales of at least $4,000 but less than $10,000, the food-to-beverage ratio shall be 35 percent and (ii) for such licensees with monthly food sales of at least $10,000, there shall be no food-to-beverage ratio requirement imposed.

Constitutional Amendments

Passed

HJ 45/SJ 3 Constitutional amendment (second reference); real property tax exemption; surviving spouses of soldiers who died in the line of duty. Expands the current tax exemption for real property available to the surviving spouses of soldiers killed in action to the surviving spouses of soldiers who died in the line of duty with a Line of Duty determination from the U.S. Department of Defense.

Carried Over

HJ 9/SJ 11 Constitutional amendment (first reference); marriage between two individuals; repeal of same-sex marriage prohibition; affirmative right to marry. Repeals the constitutional provision defining marriage as only a union between one man and one woman as well as the related provisions that are no longer valid as a result of the United States Supreme Court decision in *Obergefell v. Hodges*, 576 U.S. 644 (2015). The amendment provides that the right to marry is a fundamental right inherent in the liberty of persons and prohibits the Commonwealth and its political subdivisions from denying the issuance of a marriage license to two parties contemplating a lawful marriage on the basis of the sex, gender, or race of such parties. The Commonwealth and its political subdivisions are required to recognize any lawful marriage between two parties and to treat such marriages equally under the law, regardless of the sex, gender, or race of such parties. The amendment provides that religious organizations and clergy acting in their religious capacity have the right to refuse to perform any marriage.

Corrections

Passed

HB 159 Use of canines in correctional and juvenile correctional facilities; prohibited acts. Makes it unlawful for any correctional officer or other employee of a state correctional facility who is permitted to handle canines to use a patrol or security canine in any state correctional facility unless such correctional officer or other employee (i) reasonably believes that the use of a patrol or security canine is immediately necessary to protect any prisoner or any officer or employee from the threat of serious bodily injury or death or (ii) has the prior approval of the warden or a supervisor to use a patrol or security canine to intervene in an altercation, fight, or other incident between three or more prisoners. The bill also makes it unlawful for any juvenile correctional officer or other employee of a juvenile correctional facility to use a patrol or security canine in any juvenile correctional facility. The bill specifies that such provisions shall not apply to the training or use of detector canines or detector canine handlers.

HB 555/SB 456 Office of the Department of Corrections Ombudsman; created. Creates, within the Office of the State Inspector General, the Office of the Department of Corrections Ombudsman (the Office) headed by an Ombudsman who is selected by the State Inspector General. The bill creates the Corrections Oversight Committee (the Committee) made up of four members of the General Assembly, nine nonlegislative citizen members appointed by the Governor, subject to criteria described in the bill, and two nonvoting members, appointed as described in the bill, who monitor the activities of the Ombudsman and the Department of Corrections (the Department). The bill provides the Office with authority to conduct inspections at least once every three years, and more often when warranted, of Department facilities and requires the Office to establish a statewide toll-free telephone number, website, mailing address, and paper

and electronic forms for inmates, family members, friends, and advocates to submit complaints and inquiries. In addition, the bill requires the Committee to hold at least two public hearings per year and requires the Office to submit an annual report to be made available online and to be delivered to the Governor, the Attorney General, the Senate Committee on Rehabilitation and Social Services, the House Committee on Public Safety, the Committee, and the Director of the Department. The bill directs the Office to develop a short-term and long-term strategic plan and to provide a report on its initial activities and strategic plan to the Governor and the General Assembly on or before November 15, 2025.

HB 801 Electronic communication systems within state correctional facilities; telephone calls and communication services; lowest available rates. Requires the Department of Corrections to provide telephone systems and web-based or electronic communications systems and requires that such systems be established at the lowest available rates. The maximum number of telephone numbers permitted on an approved call list must be no fewer than 20.

HB 912 Stores and telephone systems in local correctional facilities; fees. Provides that the net profits from the operation of stores and telephonic communication systems in local correctional facilities shall be used within each facility respectively for educational, recreational, or medical purposes for the benefit of the inmates to include behavioral health, substance abuse, reentry, and rehabilitative services and may be expended to pay for the training, salaries, and benefits of employees or contractors whose primary job is to provide such programs and services to the inmates.

Failed

HB 308 Conditional release of geriatric prisoners. Expands the list of offenses that prohibit a person from petitioning the Parole Board for conditional release as a geriatric prisoner.

Courts/Civil Law

Passed

HB 174/SB 101 Marriage lawful regardless of sex, gender, or race of parties; issuance of marriage license. Provides that no person authorized to issue a marriage license shall deny the issuance of such license to two parties contemplating a lawful marriage on the basis of the sex, gender, or race of the parties. The bill also requires that such lawful marriages be recognized in the Commonwealth regardless of the sex, gender, or race of the parties. The bill provides that religious organizations or members of the clergy acting in their religious capacity shall have the right to refuse to perform any marriage.

HB 418/SB 259 Civil actions filed on behalf of multiple persons; class actions. Provides that one or more members of a class may, as representative parties on behalf of all members, bring a civil action or may be proceeded against in a civil action, provided that (i) the class is so numerous that joinder of all members or proceeding with such actions on an individual basis is impracticable or contrary to judicial economy; (ii) there are questions of law or fact common to the class; (iii) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and (iv) the representative parties shall fairly and adequately protect the interests of the class. The bill further sets out the procedure to certify a class action, the duties of counsel appointed in a class action, the various orders a court may issue during the course of a class action, and the process by which a settlement, voluntary dismissal, or compromise may occur. The bill has a delayed effective date of January 1, 2025.

HB 893 Standards for attorneys appointed to represent parents or guardians; child dependency cases; compensation; multidisciplinary law offices or programs; report. Requires the Judicial Council of Virginia, in conjunction with the Virginia State Bar, beginning July 1, 2026, to adopt standards for the qualification and performance of attorneys appointed to represent a parent or guardian of a child when such child is the subject of a child dependency case, as

defined in the bill. The bill also requires the Judicial Council of Virginia, beginning July 1, 2026, to maintain a list of attorneys admitted to practice law in Virginia who are qualified to be appointed to represent indigent parents involved in a child dependency case. Prior to July 1, 2026, counsel must be appointed from the list of attorneys qualified to serve as guardians ad litem. The bill provides that beginning January 1, 2025, court-appointed counsel for a parent, guardian, or other adult in a child dependency case will be compensated in an amount no greater than $330, or in a case for the termination of residual parental rights, $680.

The bill authorizes the establishment of up to two multidisciplinary law offices or programs in localities, jurisdictions, or judicial districts that affirm they have met specified criteria for the purpose of representing parents in a child dependency court proceeding or in a child protective services assessment or investigation prior to such proceeding. During any calendar year that such an office or program is in effect for at least six months, the office or program must submit a report on program outcomes, expenses, recommendations, and other pertinent information to the Office of the Children's Ombudsman and the Chairmen of the House Committees for Courts of Justice and on Health and Human Services and Appropriations and the Senate Committees for Courts of Justice and on Education and Health and Finance and Appropriations by November 1.

Courts/Criminal Justice

Passed

HB 18/SB 7 Hate crimes and discrimination; ethnic animosity; penalties. Provides that it is the policy of the Commonwealth to safeguard all individuals within the Commonwealth from unlawful discrimination in employment and in places of public accommodation because of such individual's ethnic origin and prohibits such discrimination. The bill also adds victims who are intentionally selected because of their ethnic origin to the categories of victims whose intentional selection for a hate crime involving assault, assault and battery, or trespass for the purpose of damaging another's property results in a higher criminal penalty for the offense. The bill also provides that no provider or user of an interactive computer service on the Internet shall be liable for any action voluntarily taken by it in good faith to restrict access to material that the provider or user considers to be intended to incite hatred on the basis of ethnic origin.

HB 81 Common-law crime of suicide. Abolishes the common-law crime of suicide. Suicide is currently a common-law crime in Virginia, although there is no statutorily prescribed punishment. The bill has a delayed effective date of July 1, 2025, and also requires the Bureau of Insurance of the State Corporation Commission to review the effect and implication of abolishing the common-law crime of suicide on insurance throughout the Commonwealth and submit its findings and any recommendations by November 1, 2024, to the Chairs of the House and Senate Committees for Courts of Justice.

HB 102/SB 356 Compensation of court-appointed counsel. Raises the limitation of fees that court-appointed counsel can receive for representation on various offenses in district and circuit courts. The bill also limits the fees charged for the cost of court-appointed counsel or public defender representation to persons determined to be indigent to an amount no greater than the amount such person would have owed if such fees had been assessed on or before June 30, 2024. The bill has a delayed effective date of January 1, 2025.

HB 267/SB 357 Assault and battery; affirmative defense; penalty. Provides an affirmative defense to prosecution of an individual for assault or assault and battery of certain specified individuals for which the enhanced Class 6 felony and six-month mandatory minimum term of confinement apply if such individual proves, by a preponderance of the evidence, that at the time of the assault or assault and battery (i) the individual's behaviors were a result of (a) mental illness or (b) a neurocognitive disorder, including dementia, or a neurodevelopmental disability, including a developmental disability or intellectual disability, such

as autism spectrum disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association or (ii) the individual met the criteria for issuance of an emergency custody order.

The bill provides that if such individual does not prove that his behaviors were a result of his mental illness, intellectual disability, developmental disability, or neurocognitive disorder but the evidence establishes that his mental illness, intellectual disability, developmental disability, or neurocognitive disorder otherwise contributed to his behaviors, the finder of fact may find the accused guilty of a misdemeanor assault or assault and battery. The bill also provides that such affirmative defense shall not be construed to allow an affirmative defense for voluntary intoxication.

HB 1420/SB 23 Juveniles; adjudication of delinquency. Specifies that a delinquent child is a child 11 years of age or older who has committed a delinquent act. Currently, there is no minimum age for a child to be adjudicated delinquent. The bill provides that if a juvenile younger than 11 years of age is found to have committed a delinquent act, the juvenile shall not be proceeded upon as delinquent; however, the court may make any orders of disposition authorized for a child in need of services or a child in need of supervision. The bill includes in the definition of "child in need of services" a child younger than 11 years of age who has committed a delinquent act.

Finally, the bill includes in the offense of causing or encouraging acts rendering children delinquent, abused, etc., any person 18 years of age or older, including the parent of any child, who willfully contributes to, encourages, or causes any act, omission, or condition that causes a child younger than 11 years of age to commit a delinquent act. Under current law, any person who commits such offense is guilty of a Class 1 misdemeanor.

SB 334 Plea agreements; prohibited provisions. Prohibits plea agreements and court orders executed or entered on or after July 1, 2024, from containing any provision that purports to waive, release, or extinguish a defendant's (i) rights under the Fourth Amendment to the United States Constitution and Article I, Section 10 of the Constitution of Virginia; (ii) right to file a petition requesting expungement of the police records and the court records; or (iii) right to have criminal history record information and court records sealed. The bill provides that any such prohibited provision of a plea agreement or court order is void and unenforceable as against public policy.

The bill provides that such prohibition does not apply to any plea agreements, written agreements, or court orders entered into by a defendant and the Commonwealth (a) as a condition for participation in a specialty docket or (b) in a case involving a sexual offense where the victim is under 18 years of age.

The bill further provides that any waiver, release, or extinguishment of rights under the Fourth Amendment permissible by law shall be no longer than the period of supervised probation or post-release supervision imposed against the defendant; if the defendant is not placed on supervised probation or post-release supervision, it shall be no longer than the period of suspension of sentence or post-release incarceration imposed against such defendant.

Failed

HB 520 Promise to appear after the issuance of a summons; issuance of summons instead of warrant in certain cases; nonviolent felonies. Provides that if any person refuses to give a written promise to appear after the issuance of a summons, the arresting officer shall give such person notice of the time and place of the hearing, note such person's refusal to give his written promise to appear on the summons, and forthwith release him from custody. Under current law, any person refusing to give such written promise to appear is required to be taken immediately by the arresting officer before a magistrate or other issuing officer having jurisdiction.

The bill also provides that a law-enforcement officer, at his discretion, may issue a summons instead of a warrant for certain felony offenses, described in the

bill, if (i) in the judgment of the officer, the person charged will cease committing the illegal act; (ii) in the judgement of the officer, the person charged does not pose an immediate threat to public safety; and (iii) the person charged signs a written promise to appear at the time and place of the hearing. The bill prohibits a law-enforcement agency from creating a policy that requires or prohibits release for persons meeting such criteria.

HB 834 Petition for modification of a sentence; eligibility; procedures. Provides a process for a person serving a sentence for any conviction or a combination of any convictions who remains incarcerated in a state or local correctional facility or secure facility and meets certain criteria to petition the circuit court that entered the original judgment or order to (i) suspend the unserved portion of such sentence or run the unserved portion of such sentence concurrently with another sentence, (ii) place such person on probation for such time as the court shall determine, or (iii) otherwise modify the sentence imposed.

SB 52 Felony homicide; certain drug offenses; penalty. Provides that a person is guilty of felony homicide, which constitutes second degree murder and is punishable by confinement of not less than five nor more than 40 years, if the underlying felonious act that resulted in the killing of another involved the manufacture, sale, gift, or distribution of a Schedule I or II controlled substance to another and (i) such other person's death results from his use of the controlled substance and (ii) the controlled substance is the proximate cause of his death. The bill provides that venue for a prosecution of this crime shall lie in the locality where the underlying felony occurred, where the use of the controlled substance occurred, or where death occurred. The bill also provides that if a person gave or distributed a Schedule I or II controlled substance only as an accommodation to another individual who is not an inmate in a community correctional facility, local correctional facility, or state correctional facility, or in the custody of an employee thereof, and not with intent to profit thereby from any consideration received or expected nor to induce the recipient of the controlled substance to use or become addicted to or dependent upon such controlled substance, he is guilty of a Class 5 felony.

SB 503 License plate reader systems; civil penalty. Provides requirements for the use of license plate reader systems, defined in the bill, by law-enforcement agencies. The bill limits the use of such systems to scanning, detecting, and recording data about vehicles and license plate numbers for the purpose of identifying a vehicle that is (i) associated with a wanted, missing, or endangered person or human trafficking; (ii) stolen; (iii) involved in an active law-enforcement investigation; or (iv) in the vicinity of a recent crime and may be connected to that crime. The bill authorizes and requires the Commonwealth Transportation Board to establish a permitting process for installing and using such systems in state highway rights-of-way.

Education

Passed

HB 48/SB 46 Public institutions of higher education; admissions applications; legacy admissions and admissions based on donor status prohibited. Prohibits any public institution of higher education from providing any manner of preferential treatment in the admissions decision to any student applicant on the basis of such student's legacy status, defined in the bill, or such student's familial relationship to any donor to such institution.

HB 624/SB 105 Public school staffing and funding; National Teacher Certification Incentive Reward Program and Fund; At-Risk Program; English language learner students. Renames the National Teacher Certification Incentive Reward Program and Fund as the National Board Certification Incentive Reward Program and Fund, expands eligibility for incentive grant awards from such Fund pursuant to such Program from solely teachers who have obtained national certification from the National Board for Professional Teaching Standards to all public school staff who are candidates for initial national certification or maintenance of national certification to cover certain costs of obtaining or maintaining such certification and

all public school staff who have successfully obtained or maintained such certification, and permits certain teachers to apply for additional incentive grants pursuant to such Program and Fund. The bill also establishes the At-Risk Program for the purpose of supporting programs and services for students who are educationally at risk, including prevention, intervention, or remediation activities required pursuant to relevant law, teacher recruitment programs and initiatives, programs for English language learners, the hiring of additional school counselors and other support staff, and other programs relating to increasing the success of disadvantaged students in completing a high school degree and providing opportunities to encourage further education and training. The bill also contains provisions relating to certain funding requirements for the At-Risk Program. Finally, the bill requires state funding to be provided pursuant to the general appropriation act to support ratios of instructional positions to English language learner students based on each such student's English proficiency level, as established in the general appropriation act.

HB 732/SB 726 Public schools; opioid antagonist procurement, possession, and administration; school board employee training and certification; opioid overdose prevention and reversal instruction; guidelines and requirements. Requires each local school board to develop, in accordance with the guidelines developed by the Department of Health in collaboration with the Department of Education, plans, policies, and procedures for (i) providing at each public secondary school that includes grades nine through 12 a program of instruction on opioid overdose prevention and reversal and for encouraging each student to complete such program of instruction prior to graduation; (ii) the procurement, placement, and maintenance in each public elementary and secondary school of a supply of opioid antagonists in an amount equivalent to at least two unexpired doses for the purposes of opioid overdose reversal; and (iii) the possession and administration of an opioid antagonist by any employee of the school board who is authorized by a prescriber and trained in the administration of an opioid antagonist, including policies (a) requiring each public elementary and secondary school to ensure that at least one employee is authorized by a prescriber and trained and certified in the administration of an opioid antagonist, (b) for partnering with a program administered or approved by the Department of Health to provide such training and certification, and (c) for maintaining records of each such trained and certified employee.

The bill provides for the disciplinary, civil, and criminal immunity of any employee of a public school, school board, or local health department, regardless of whether such employee was trained or certified in opioid antagonist administration, for any act or omission made in connection with the good faith administration of an opioid antagonist for the purposes of opioid overdose reversal during regular school hours, on school premises, or during a school-sponsored activity, unless such act or omission was the result of gross neglect or willful misconduct. The bill requires each school board to adopt and each public elementary and secondary school to implement policies and procedures in accordance with the provisions of the bill and, in doing so, to utilize to the fullest extent possible programs offered by the Department of Health for the provision of opioid antagonist administration training and certification and opioid antagonist procurement.

In addition, the bill modifies the school board employees who are authorized to administer opioid antagonists to include any school board employee who has completed training and is certified in the administration of an opioid antagonist by a program administered or authorized by the Department of Health.

Finally, the bill directs the Department of Health and the Department of Education to collaborate to develop guidelines and policies for the implementation of the provisions of the bill and requires each school board to implement the provisions of the bill by the beginning of the 2025–2026 school year.

Failed

HB 1164/SB 533 Education Excellence for All Program established. Permits the parents of qualified students, defined in the bill, to apply for a one-year, renewable Education Excellence for All Savings Account, defined in the bill, that consists of an amount that is equivalent to a certain percentage of all applicable annual Standards of Quality per pupil state funds appropriated for public school purposes and apportioned to the school division in which the qualified student resides, including the per pupil share of state sales tax funding in basic aid and any per pupil share of state special education funding for which the qualified student is eligible. The bill permits the parent of the qualified student to use the moneys in such account for certain qualified expenses of the qualified student, including tuition, deposits, fees, and required textbooks at a private elementary school or secondary school that is located in the Commonwealth. The bill also contains provisions relating to program and account administration by the Department of the Treasury and a third party that serves as program administrator pursuant to a contract with the Department.

Firearms/Weapons

Passed

HB 2/SB 2 Purchase, sale, transfer, etc., of assault firearms and certain ammunition feeding devices prohibited; penalty. Creates a Class 1 misdemeanor for any person who imports, sells, manufactures, purchases, or transfers an assault firearm, as that term is defined in the bill, and prohibits a person who has been convicted of such violation from purchasing, possessing, or transporting a firearm for a period of three years from the date of conviction. The bill provides that an assault firearm does not include any firearm that is an antique firearm, has been rendered permanently inoperable, is manually operated by bolt, pump, lever, or slide action, or was manufactured before July 1, 2024. The bill also prohibits the sale of a large capacity ammunition feeding device, as that term is defined in the bill. The bill provides that any person who willfully and intentionally (i) sells an assault firearm to another person or (ii) purchases an assault firearm from another person is guilty of a Class 1 misdemeanor and that any person who imports, sells, barters, or transfers a large capacity ammunition feeding device is guilty of a Class 1 misdemeanor. The bill also makes it a Class 1 misdemeanor for any person younger than 21 years of age to import, sell, manufacture, purchase, possess, transport, or transfer an assault firearm regardless of the date of manufacture of such assault firearm.

HB 22/SB 210 Manufacture, importation, sale, etc., of auto sears; prohibition; penalty. Prohibits the manufacture, importation, sale or offer to sell, possession, transfer, or transportation of an auto sear, defined in the bill as a device, other than a trigger activator, for use in converting a semi-automatic firearm to shoot automatically more than one shot, without manual reloading, by a single function of the trigger. A violation is punishable as a Class 6 felony. The bill also provides for the forfeiture of any auto sear concealed, possessed, transported, or carried in violation of the prohibition.

HB 173/SB 100 Manufacture, import, sale, transfer, or possession of plastic firearms and unfinished frames or receivers and unserialized firearms prohibited; penalties. Creates a Class 5 felony for any person who knowingly manufactures or assembles, imports, purchases, sells, transfers, or possesses any firearm that, after removal of all parts other than a major component, as defined in the bill, is not detectable as a firearm when subjected to inspection by the types of detection devices, including X-ray machines, commonly used at airports, government buildings, schools, correctional facilities, and other locations for security screening. The bill updates language regarding the types of detection devices that are used at such locations for detecting plastic firearms. Under current law, it is unlawful to manufacture, import, sell, transfer, or possess any plastic firearm and a violation is punishable as a Class 5 felony.

The bill also creates a Class 1 misdemeanor, which is

punishable as a Class 4 felony for a second or subsequent offense, making it unlawful for any person to knowingly possess a firearm or any completed or unfinished frame or receiver that is not imprinted with a valid serial number or to knowingly import, purchase, sell, offer for sale, or transfer ownership of any completed or unfinished frame or receiver, unless the completed or unfinished frame or receiver (i) is deemed to be a firearm pursuant to federal law and (ii) is imprinted with a valid serial number. The bill creates a Class 1 misdemeanor, which is punishable as a Class 4 felony for a second or subsequent offense, making it unlawful for any person to manufacture or assemble, cause to be manufactured or assembled, import, purchase, sell, offer for sale, or transfer ownership of any firearm that is not imprinted with a valid serial number. The portions of the bill prohibiting unfinished frames or receivers and unserialized firearms have a delayed effective date of January 1, 2025; however, the portions of the bill prohibiting the knowing possession of a firearm or any completed or unfinished frame or receiver that is not imprinted with a valid serial number have a delayed effective date of July 1, 2025.

HB 175/SB 99 Carrying assault firearms in public areas prohibited; penalty. Prohibits the carrying of certain semi-automatic center-fire rifles and shotguns on any public street, road, alley, sidewalk, or public right-of-way or in any public park or any other place of whatever nature that is open to the public, with certain exceptions. Under current law, the current prohibition on carrying certain shotguns and semi-automatic center-fire rifles and pistols applies to a narrower range of firearms, only in certain localities, and only when such firearms are loaded.

HB 362/SB 642 Purchase, possession, or transportation of firearm; assault and battery of a family or household member or intimate partner; penalties. Adds to the existing definition of "family or household member" a person's intimate partner, defined in the bill as an individual who, within the previous 12 months, was in a romantic, dating, or sexual relationship with the person. The bill also provides that any person who knowingly and intentionally purchases, possesses, or transports any firearm following a misdemeanor conviction for an offense that occurred on or after July 1, 2024, for the offense of assault and battery against an intimate partner or an offense substantially similar under the laws of any other state or of the United States is guilty of a Class 1 misdemeanor.

HJ 76/SB 338 Study; JLARC; effects of gun violence on communities; report. Directs the Joint Legislative Audit and Review Commission to conduct a two-year study of the social, physical, emotional, and economic effects of gun violence on communities across the Commonwealth.

Failed

HB 389 Carrying a concealed handgun; permit not required. Allows any person who is otherwise eligible to obtain a concealed handgun permit to carry a concealed handgun without a permit anywhere he may lawfully carry a handgun openly within the Commonwealth.

Freedom of Information Act

Passed

HB 816/SB 244 Virginia Freedom of Information Act; effective date of procedures for conducting meetings held through electronic communication means during declared states of emergency. Provides that the provisions for conducting a meeting by electronic means due to a state of emergency stated in the Virginia Freedom of Information Act (FOIA) are declarative of existing law since March 20, 2020, with respect to the Governor's declared state of emergency due to COVID-19. Under the bill, any meeting by a public body using electronic communication means occurring from that date until July 1, 2021, and any otherwise lawful action taken at it is validated with respect to FOIA if the body provided public notice, public access, and public comment commensurate with the requirements of existing FOIA provisions regarding electronic and closed meetings. The bill is a response to the case *Berry v. Bd. of Supervisors* (Va. 2023) and is a recommendation of the Virginia Freedom of Information Advisory Council.

HB 818/SB 36 Virginia Freedom of Information Act; definitions of meetings and public business. Exempts certain public meetings from the definition of "meeting" under the Virginia Freedom of Information Act to clarify that three or more members of a public body may appear and participate in such public meeting without violating the Act, provided that no public business is transacted or discussed. The bill also exempts members of a public body who attend a public meeting of a second public body without violating the Act, provided that no public business is transacted or discussed. Finally, the bill defines "public business" as activity that a public body has undertaken or proposed to undertake on behalf of the people it represents. The bill states that its provisions are declarative of existing law.

HB 894/SB 734 Virginia Freedom of Information Act; electronic meetings. Amends the number of all-virtual public meetings that public bodies, with certain exceptions, may convene in a calendar year to no more than two times per calendar year or 50 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater. Current law limits the number of all-virtual public meetings to no more than two times per calendar year or 25 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater. The bill also provides that with respect to all-virtual public meetings, when audio-visual technology is available, a member of a public body shall, for purposes of a quorum, be considered absent from any portion of the meeting during which visual communication with the member is voluntarily disconnected or otherwise fails or during which audio communication involuntarily fails.

HB 1040/SB 85 Virginia Freedom of Information Act; definition of "caregiver"; remote participation in meetings by persons with disabilities and caregivers; remote voting. Provides that for purposes of determining whether a quorum is physically assembled, an individual member of a public body who is a person with a disability or a caregiver, defined in the bill, and uses remote participation counts toward the quorum as if the individual was physically present. The bill also provides that the participation policy adopted by a public body, as required by the Virginia Freedom of Information Act, shall not prohibit or restrict any individual member of a public body who is participating in an all-virtual meeting or who is using remote participation from voting on matters before the public body. As introduced, the bill was a recommendation of the Virginia Freedom of Information Advisory Council.

General Laws

Passed

HB 442 Virginia Residential Landlord and Tenant Act; landlord remedies; noncompliance with rental agreement; payment plan. Requires a landlord who owns more than four rental dwelling units or more than a 10 percent interest in more than four rental dwelling units, before terminating a rental agreement due to nonpayment of rent if the exact amount of rent owed is less than or equal to one month's rent plus any late charges contracted for in the rental agreement and as provided by law, to serve upon such tenant a written notice informing the tenant of the exact amount due and owed and offer the tenant a payment plan under which the tenant must pay the exact amount due and owed in equal monthly installments over a period of the lesser of six months or the time remaining under the rental agreement. The bill prohibits the landlord from charging any additional late fees during the payment plan period in connection with the unpaid rental amount for which the tenant entered into the payment plan so long as the tenant makes timely payments in accordance with the terms of the payment plan. The bill also outlines the remedies a landlord has if a tenant fails to pay the exact amount due and owed or enter into a payment plan within five days of receiving notice or if a tenant enters into a payment plan and after such plan becomes effective fails to pay rent when due or fails to make a payment under the terms of the agreed-upon payment plan.

HB 1108/SB 18 Virginia Public Procurement Act; construction management and design-build contracting. Requires state public bodies, covered institutions, and local public bodies to provide

documentation of the processes used for the final selection of a construction contract to all the unsuccessful applicants upon request. The bill adds certain requirements for covered institutions, including posting all documents that are open to public inspection exchanged between the Department of General Services and the covered institution on the central electronic procurement website eVA. The bill requires approval by a majority vote of the covered institution's board of visitors or governing board if the covered institution chooses to proceed with construction management or design-build against the recommendation of the Department for (i) projects funded by funds other than those provided from the state general fund or (ii) projects of $65 million or more funded in whole or in part from state general funds. For projects under $65 million funded in whole or in part by state general funds, the bill provides that the covered institution shall obtain approval from the Chairmen of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations, or their designees, and a representative of the Department.

The bill requires a local public body to adopt a resolution or motion to use construction management or design-build, if required by its local governing body, prior to issuing a Request for Qualifications and to publish notice of such resolution or motion on its website or eVA. The bill provides that the Department shall report annually, for any construction management or design-build project, on the qualifications that made such project complex. Finally, the bill requires the Department, with the assistance of staff of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations, to assess the implementation and administration of construction management and design-build projects and report its findings and recommendations to the General Assembly by November 1, 2029.

HB 1131/SB 541 Casino gaming; eligible host city. Removes the City of Richmond as an eligible host city for casino gaming establishments in the Commonwealth.

Failed

HB 877 Virginia Social Media Regulation Act established; penalties. Establishes the Virginia Social Media Regulation Act for the purpose of prohibiting minors in Virginia from possessing an account on any social media platform, defined in the bill, without the express consent of a parent or guardian. The bill requires a social media company to provide a minor's parent or guardian with access to the minor's account and all posts and information on such account. The bill also places prohibitions on the type of data and personal information a social media platform may collect from a minor account holder and prohibits the use of any practice, design, or feature on a social media company's platform that the company knows, or should reasonably know, could cause a minor account holder to have an addiction to the social media platform. Lastly, the bill provides that any violation of the Virginia Social Media Regulation Act shall constitute a prohibited practice and be subject to the enforcement provisions of the Virginia Consumer Protection Act.

HB 1158 Administrative Process Act; executive branch agencies. Requires executive branch agencies to ensure that certain regulations and guidance documents under the Virginia Register Act and Administrative Process Act, as appropriate, are posted on the Virginia Regulatory Town Hall according to instructions issued by the Department of Planning and Budget.

HB 1478/SB 689 Casino gaming; cruise ships. Authorizes the conduct of cruise ship casino gaming in the offshore waters of the Commonwealth by a cruise ship operator that applies for and receives a permit from the Virginia Lottery. The bill sets an annual permit fee of $50,000 for any cruise ship that uses a port or other point of anchorage in the offshore waters of the Commonwealth for the purpose of embarkation or disembarkation of cruise ship passengers and an annual permit fee of $125,000 for any cruise ship that transits the offshore waters of the Commonwealth without making a stop in the Commonwealth and conducts casino gaming activities while in such waters.

Health

Passed

HB 188/SB 154 Advance Health Care Planning Registry; amendment of regulations. Amends the list of documents that may be submitted to the Advance Health Care Directive Registry to include any other document that supports advance health care planning. The bill also changes the name of the Advance Health Care Directive Registry to the Advance Health Care Planning Registry. The bill directs the Department of Health to amend certain Advance Health Care Planning Registry regulations.

HB 609/SB 237 Contraception; right to contraception; applicability; enforcement. Establishes a right to obtain contraceptives and engage in contraception, as defined in the bill. The bill creates a cause of action that may be instituted against anyone who infringes on such right.

HB 909/SB 488 Department of Medical Assistance Services; Department of Behavioral Health and Developmental Services; 1915(c) Home and Community Based Services Medicaid Waivers; state plan amendments; program rule modifications. Directs the Department of Medical Assistance Services (DMAS) and the Department of Behavioral Health and Developmental Services to seek federal authority through the necessary state plan amendments under Titles XIX and XXI of the Social Security Act to modify the program rules for certain 1915(c) Home and Community Based Services Medicaid Waivers to (i) modify the 40-hour-per-week work limit to allow legally responsible individuals with more than one waiver-receiving child to receive reimbursement for 40 hours of work per week per child receiving a waiver; (ii) eliminate the requirement that, in order for a legally responsible individual to receive reimbursement for personal care services, no one else be available to provide services to the member; and (iii) modify the program rules to allow a legally responsible individual or stepparent to be the employer of record. The bill directs DMAS to evaluate the possibility of allowing for respite services under certain 1915(c) Home and Community Based Services Medicaid Waivers and submit its recommendations, cost estimate, and methodology used for obtaining the cost estimate to the General Assembly no later than November 1, 2024.

SB 553 Board of Nursing; certain nursing education programs; out-of-state clinical sites. Directs the Board of Nursing to amend its regulations to permit nursing education programs in the Commonwealth located within 60 miles of a bordering state or the District of Columbia to contract for an unlimited number of required clinical hours at out-of-state clinical sites. The bill requires the regulations to specify that the Board must accept such hours for licensure.

Failed

HB 970/SB 231 Comprehensive children's health care coverage program. Directs the Department of Medical Assistance Services (the Department) to establish a program to provide state-funded comprehensive health care coverage for individuals in the Commonwealth who (i) are under 19 years of age, (ii) are not covered under a group health plan or health insurance coverage, and (iii) but for their immigration status would be eligible for medical assistance services through the Commonwealth's program of medical assistance services established pursuant to Title XIX or XXI of the Social Security Act. The bill also requires the Department to ensure that all program information is made available in a manner that is accessible to individuals with limited English proficiency and individuals with disabilities through the provision of language access services, including oral interpretation and written translations, free of charge and to ensure that information obtained by the program remains confidential and is not disclosed for any purpose not related to the administration of the program or any purpose related to civil immigration enforcement unless the subject of the information consents to such disclosure or the requesting agency presents a valid judicial order, subpoena, or warrant.

The bill also requires the Department to (a) consult with individuals with direct and lived experience with the program eligibility criteria established by the bill and

individuals with experience conducting outreach to individuals who are eligible for the program established by the bill to advise and assist the Department in carrying out marketing and outreach activities required by the bill and (b) seek all federal waivers and other approvals necessary to maximize federal financial participation in the cost of carrying out the program established by the bill.

SB 499 Donor human milk banks, health insurance; coverage for donor human milk; penalty; emergency. Prohibits any person from establishing or operating a donor human milk bank, as defined in the bill, without first obtaining a license from the State Health Commissioner and makes it a Class 6 felony for any person to establish or operate a donor human milk bank in the Commonwealth without obtaining such license. The bill directs the State Board of Health to establish a regulatory and statutory scheme for the licensure and regulation of donor human milk banks operating or doing business in the Commonwealth. The bill also directs the Commissioner to implement and enforce numerous regulations relating to the issuance, renewal, denial, suspension, and revocation of such licenses. The bill specifies procedures relating to disciplinary actions, application fees, and inspections and interviews related to such donor human milk banks.

The bill requires health insurers, corporations providing health care coverage subscription contracts, and health maintenance organizations to provide coverage for expenses incurred in the provision of pasteurized donor human milk. The bill specifies that the requirement applies if the covered person is an infant younger than the age of six months and a licensed medical practitioner has issued an order for such infant who satisfies certain criteria enumerated in the bill. The bill applies to policies, contracts, and plans delivered, issued for delivery, or renewed on or after January 1, 2026. The bill also requires the state plan for medical assistance services to include a provision for payment of medical assistance services incurred in the provision of pasteurized donor human milk. The bill specifies that certain provisions will not become effective until the State Board promulgates regulations for the licensure of donor human milk banks and directs the State Board to adopt emergency regulations to implement certain provisions of the bill.

Labor and Commerce

Passed

HB 1/SB 1 Minimum wage. Increases the minimum wage from the current rate of $12.00 per hour to $13.50 per hour effective January 1, 2025, and to $15.00 per hour effective January 1, 2026. The bill satisfies a reenactment clause included in Chapters 1204 and 1242 of the Acts of Assembly of 2020.

HB 108/SB 255 Shared solar programs; American Electric Power; minimum bill; capacity. Requires the State Corporation Commission to establish by regulation a shared solar program, as defined in the bill, through which customers of American Electric Power may purchase electric power through a subscription in a shared solar facility, as defined in the bill. The bill requires the Commission to establish a minimum bill, which shall include the costs of all utility infrastructure and services used to provide electric service and administrative costs of the shared solar program, taking into account certain considerations. The bill directs the Commission to initiate a proceeding to recalculate such minimum bill within 30 days of its final order in a proceeding establishing the value of a solar renewable energy certificate as required by relevant law. The bill specifies that the Commission shall establish the shared solar program consistent with the requirements of the bill by January 1, 2025, and shall require each utility to file any associated tariffs, agreements, or forms necessary for implementing the program by July 1, 2025. Additionally, the bill requires the Department of Energy to convene a stakeholder work group to determine the amounts and forms of certain project incentives and to submit a written report to the Chairs of the House Committee on Labor and Commerce and the Senate Committee on Commerce and Labor no later than November 30, 2024.

HB 570/SB 274 Prescription Drug Affordability Board established; drug cost affordability review. Establishes the Prescription Drug Affordability Board for the purpose of protecting the citizens of the Commonwealth and other stakeholders within the health care system from the high costs of prescription drug products. The bill requires the Board to meet in open session at least four times annually, with certain exceptions and requirements enumerated in the bill. Members of the Board are required to disclose any conflicts of interest, as described in the bill. The bill also creates a stakeholder council for the purpose of assisting the Board in making decisions related to drug cost affordability. The bill tasks the Board with identifying prescription, generic, and other drugs, as defined in the bill, that are offered for sale in the Commonwealth and, at the Board's discretion, conducting an affordability review of any prescription drug product. The bill lists factors for the Board to consider that indicate an affordability challenge for the health care system in the Commonwealth or high out-of-pocket costs for patients. The bill also provides that any person aggrieved by a decision of the Board may request an appeal of the Board's decision and that the Attorney General has authority to enforce the provisions of the bill. The bill provides that the Board shall establish no more than 12 upper payment limit amounts annually between January 1, 2025, and January 1, 2028.

The bill requires the Board to report its findings and recommendations to the General Assembly twice annually, beginning on July 1, 2025, and December 31, 2025. Provisions of the bill shall apply to state-sponsored and state-regulated health plans and health programs and obligate such policies to limit drug payment amounts and reimbursements to an upper payment limit amount set by the Board, if applicable, following an affordability review. The bill specifies that Medicare Part D plans shall not be bound by such decisions of the Board.

The bill also requires the nonprofit organization contracted by the Department of Health to provide prescription drug price transparency to provide the Board access to certain data reported by manufacturers. The bill has a delayed effective date of January 1, 2025.

HB 990/SB 370 Prohibiting employer seeking wage or salary history of prospective employees; wage or salary range transparency; cause of action. Prohibits a prospective employer from (i) seeking the wage or salary history of a prospective employee; (ii) relying on the wage or salary history of a prospective employee in determining the wages or salary the prospective employee is to be paid upon hire; (iii) relying on the wage or salary history of a prospective employee in considering the prospective employee for employment; (iv) refusing to interview, hire, employ, or promote a prospective employee or otherwise retaliating against a prospective employee for not providing wage or salary history; and (v) failing or refusing to disclose in each public and internal posting for each job, promotion, transfer, or other employment opportunity the wage, salary, or wage or salary range. The bill establishes a cause of action for an aggrieved prospective employee or employee and provides that an employer that violates such prohibitions is liable to the aggrieved prospective employee or employee for statutory damages between $1,000 and $10,000 or actual damages, whichever is greater, reasonable attorney fees and costs, and any other legal and equitable relief as may be appropriate.

HB 1404 Department of Small Business and Supplier Diversity; Small SWaM Business Procurement Enhancement Program established; disparity study; report. Establishes the Small SWaM Business Procurement Enhancement Program with a statewide goal of 42 percent of certified small SWaM business utilization in all discretionary spending by executive branch agencies and covered institutions in procurement orders, prime contracts, and subcontracts, as well as a target goal of 50 percent subcontracting to small SWaM businesses in instances where the prime contractor is not a small SWaM business for all new capital outlay construction solicitations that are issued. The bill provides that executive branch agencies and covered institutions are required to increase their small SWaM business utilization rate by three percent per year until reaching the 42-percent target level or, if unable to do so, to implement achievable goals to increase their utilization rate. In addition, the bill provides for a small SWaM business set-aside for executive branch agency and covered institution

purchases of goods, services, and construction, requiring that purchases up to $100,000 be set aside for award to certified small SWaM businesses.

The bill creates the Division of Procurement Enhancement within the Department of Small Business and Supplier Diversity for purposes of collaborating with the Department of General Services, the Virginia Information Technologies Agency, the Department of Transportation, and covered institutions to further the Commonwealth's efforts to meet the goals established under the Small SWaM Business Procurement Enhancement Program, as well as implementing initiatives to enhance the development of small businesses, microbusinesses, women-owned businesses, minority-owned businesses, and service disabled veteran-owned businesses in the Commonwealth.

Finally, the bill requires the Department of Small Business and Supplier Diversity to conduct a disparity study every five years, with the next disparity study due no later than January 1, 2026. The bill specifies that the study shall evaluate the need for enhancement and remedial measures to address the disparity between the availability and the utilization of women-owned and minority-owned businesses. The provisions of the bill other than those requiring a disparity study have a delayed effective date of January 1, 2025, and apply to covered institutions beginning July 1, 2025.

Failed

HB 107 Electric Vehicle Rural Infrastructure Program and Fund created. Creates the Electric Vehicle Rural Infrastructure Program and Fund to assist private developers with non-utility costs associated with the installation of public electric vehicle charging stations in certain localities. The bill provides that a private developer is eligible to receive grants of 70 percent of such non-utility costs for public electric vehicle charging stations installed in a city or county that meets the criteria of a distressed locality, as defined in the bill. The bill has an expiration date of July 1, 2028.

Social Services

Passed

HB 27/SB 39 Kinship foster care; alternative living arrangements; Parental Child Safety Placement Program established. Establishes the Parental Child Safety Placement Program to promote and support placements of children with relatives by local boards of social services in order to avoid foster care. The bill establishes the requirements for a parental child safety placement agreement, the procedure for assessing a proposed caregiver, and the process for terminating the placement.

HB 908/SB 676 Department of Medical Assistances Services; financial eligibility standards for certain waivers providing services to individuals with developmental disabilities. Directs the Department of Medical Assistance Services (the Department) to amend the financial eligibility standards for individuals receiving services under the Family and Individual Support Waiver, Community Living Waiver, and Building Independence Waiver (the DD Waivers). The bill requires the Department, when determining financial eligibility for the DD Waivers, to disregard any Social Security Disability Insurance income above the maximum monthly Supplemental Security Income as determined by the U.S. Social Security Administration; however, such Social Security Disability Insurance income shall not be disregarded for purposes of determining an individual's patient pay obligation. The bill also requires the Department to (i) analyze the implications of such amendments to the financial eligibility standards for individuals under the DD waivers, which shall include a determination of the costs and the number of individuals who would benefit from such amendments and (ii) report its findings to the Chairmen of the Senate Committees on Education and Health and Finance and Appropriations and the House Committees on Health and Human Services and Appropriations no later than November 1, 2024. The bill sunsets on July 1, 2026.

Failed

SB 476 Earned sentence credits; inchoate offenses; concurrent and consecutive sentences. Provides that a person who is convicted of an inchoate offense will earn sentence credits at the same rate as someone who is convicted of the completed offense for certain enumerated offenses. The bill also specifies that the provision in current law providing that a person who has been convicted of certain enumerated offenses may earn a maximum of 4.5 sentence credits for each 30 days served on any sentence for such offenses also applies to any other sentence that is to be served concurrent with or consecutive to any such sentence. The bill also clarifies that the provisions regarding the earning of credits for concurrent and consecutive sentences apply retroactively.

Taxation

Passed

HB 25/SB 116 Annual retail sales and use tax holiday. Establishes an annual retail sales and use tax holiday that takes place on the first full weekend in August beginning on July 1, 2025, through July 1, 2030. During such weekend, state retail sales and use tax will not apply to certain (i) school supplies, (ii) clothing and footwear, (iii) qualified products designated as Energy Star or WaterSense, (iv) portable generators, or (v) hurricane preparedness equipment.

HB 790/SB 582 Purchase, possession, and sale of retail tobacco products; retail tobacco products and liquid nicotine tax; penalties. Prohibits Internet sales of liquid nicotine or nicotine vapor products, except to a retail dealer, and prohibits the sale of retail tobacco products from vending machines. The bill updates, for the purpose of the crime of selling or distributing tobacco products to a person younger than 21 years of age, the definition of "retail tobacco products" by including in such definition products currently defined as "nicotine vapor products" or "alternative nicotine vapor products." The bill also removes provisions prohibiting the attempt to purchase, the purchase, or the possession of tobacco products by persons younger than 21 years of age.

The bill provides that the punishment of a retail dealer that sells, gives, or furnishes a tobacco product to a person younger than 21 years of age or to a person who does not demonstrate that such person is at least 21 years of age is (i) a civil penalty of $1,000 for a first offense within a 36-month period, (ii) a civil penalty of $5,000 for a second offense within a 36-month period and becomes subject to specific age-verification requirements, (iii) a civil penalty of $10,000 and a 30-day suspension of such establishment's distributor's license for a third offense within a 36-month period, and (iv) revocation of such license and such distributor shall be ineligible to hold a license for a period of three years following the most recent violation for a fourth offense within a 36-month period. The bill requires the Department of Taxation, in collaboration with the Virginia Alcoholic Beverage Control Authority and local law enforcement, to conduct a compliance check every 24 months on any retailer selling retail tobacco products and to use a person younger than 21 years of age to conduct such checks.

The bill also imposes a tax upon liquid nicotine in closed systems, as defined in the bill, at the rate of $0.066 per milliliter and upon liquid nicotine in open systems, as defined in the bill, at the rate of 20 percent of the wholesale price for purchases on and after July 1, 2024. The bill applies licensing requirements to manufacturers, distributors, and retail dealers of liquid nicotine and creates new safety requirements related to the advertising, marketing, and labeling of liquid nicotine and nicotine vapor products.

HB 805/SB 14 Additional local sales and use tax to support schools; referendum. Authorizes all counties and cities to impose an additional local sales and use tax at a rate not to exceed one percent with the revenue used only for capital projects for the construction or renovation of schools if such levy is approved in a voter referendum. The bill removes the requirement that such a tax must have an expiration date on either (i) the date of the repayment of any bonds or loans used for such

capital projects or (ii) a date chosen by the governing body. Under current law, only Charlotte, Gloucester, Halifax, Henry, Mecklenburg, Northampton, Patrick, and Pittsylvania Counties and the City of Danville are authorized to impose such a tax.

Failed

HB 1514/SB 718 Virginia Sports and Entertainment Authority and Financing Fund established; report. Establishes the Virginia Sports and Entertainment Authority as a political subdivision charged with financing the construction of a sports and entertainment campus. The Authority is composed of nine members, six of whom are appointed by the Governor and three of whom are appointed by the governing body of the City of Alexandria. Each appointed member is subject to specific criteria for appointment. The bill authorizes the Authority to hire independent contractors, enter contracts, acquire property, borrow money, and exercise other similar powers and exempts it from the Personnel Act and the Public Procurement Act. Under the bill, the Authority may issue bonds with a maximum maturity date of 40 years.

The bill entitles the Authority to the following revenues: (i) sales tax revenues from construction and transactions on the campus, defined in the bill, but certain revenues that current law dedicates to transportation and education are excluded; (ii) all pass-through entity tax revenues and corporate income tax revenues from income generated by the company, defined in the bill, or any professional sports team or any affiliates as well as in the development and construction of the campus; and (iii) all personal income tax revenues from income generated through employment and business activity on the campus. It also authorizes the City of Alexandria to appropriate tax revenues to the Authority.

The revenues shall be deposited in the Virginia Sports and Entertainment Authority Financing Fund, created in the bill, from which the Authority will deposit revenues into priority accounts for Authority revenues, debt service, subordinate debt service, reserves, and capital expenditures and maintenance. If the Authority determines that all such accounts are sufficiently funded, the bill directs the Authority to issue the excess to the Commonwealth and the City of Alexandria if so provided for in any bond or financing agreements.

Transportation/Motor Vehicles

Passed

HB 282 Moving violations; highway work zones. Creates a traffic infraction for any moving violation in a highway work zone punishable by a fine of not less than $300 for the first offense and not less than $500 for any subsequent offense. The bill provides that for any subsequent offense that occurs within the same 12-month period as another such offense such fine shall be not less than $750.

HB 812 Special license plates; Sons of Confederate Veterans and Robert E. Lee. Repeals authorization for the issuance of Sons of Confederate Veterans and Robert E. Lee special license plates and provides that such special license plates already in circulation will remain valid until their expiration and shall not be renewed.

HB 925 Towing; vehicles with expired registration; civil penalty. Requires a towing operator, defined in the bill, for a parking lot of a multifamily dwelling unit, defined in the bill, to post written notice on a vehicle providing at least 48 hours' notice to a resident prior to removing a resident's vehicle, defined in the bill, from such parking lot of the multifamily dwelling unit for an expired registration or expired vehicle inspection sticker and to provide a copy of such notice to the landlord of such multifamily dwelling unit. The bill provides that a towing operator who fails to comply with these requirements shall be required to reimburse the resident for the cost of the tow and shall be subject to a civil penalty not to exceed $100.

HB 1454/SB 246 Limited-duration licenses and driver privilege cards and permits; expiration. Extends the validity of limited-duration licenses, driver privilege cards and permits, and identification privilege cards, other than REAL ID credentials and commercial

driver's licenses and permits, to a period of time consistent with the validity of driver's licenses, which, under current law, is a period not to exceed eight years or, for a person age 75 or older, a period not to exceed five years, and permits and special identification cards. The bill directs the Department of Motor Vehicles to implement the extended validity periods for such documents upon reissuance.

SJ 28 Study; joint subcommittee; funding needs in certain transit systems; report. Establishes a joint subcommittee to study long-term, sustainable, dedicated funding and cost-containment controls and strategies to ensure the Washington Metropolitan Area Transit Authority, the Virginia Railway Express, and the public transit systems that serve the Northern Virginia Transportation Commission and Potomac and Rappahannock Transportation Commission transportation districts meet the growing needs of public transit in the region.

Failed

HB 657 Pedestrian control signals; applicability to persons riding bicycles and other devices. Allows persons riding a bicycle, electric personal assistive mobility device, electric power-assisted bicycle, moped, or motorized skateboard or scooter to, while remaining in the travel lane, follow the pedestrian control signal corresponding to the person's direction of travel, provided that they travel straight or turn right and yield to pedestrians lawfully in the crosswalk and any vehicle approaching the intersection from the right.

HB 1077 Exception to stopping requirement; bicycle, electric personal assistive mobility device, electric power-assisted bicycle, or motorized skateboard or scooter. Authorizes the operator of a bicycle, electric personal assistive mobility device, electric power-assisted bicycle, or motorized skateboard or scooter to yield instead of stop at an intersection controlled by a stop sign if (i) each intersecting highway has no more than three motor vehicle travel lanes; (ii) the operator is at least 15 years of age or accompanied by an adult; (iii) the operator slows to a reasonable speed based on existing conditions; and (iv) before proceeding into the intersection, the person stops for any pedestrian within the crosswalk and for any other vehicle approaching or entering such intersection from another direction.

HB 1266 Traffic; bicycles and certain other vehicles. Clarifies that the roadways on which bicycles, electric personal assistive mobility devices, electric power-assisted bicycles, motorized skateboards or scooters, or mopeds are exempt from the requirement to ride as close as safely practicable to the right curb include those not wide enough to allow an overtaking motor vehicle to pass as required by law. The bill removes the requirement for persons riding bicycles, electric personal assistive mobility devices, electric power-assisted bicycles, or motorized skateboards or scooters on a highway two abreast to move into a single-file formation when being overtaken by a faster-moving vehicle and limits the requirement that such persons not impede the normal and reasonable movement of traffic to roadways with only one travel lane per direction and a posted speed limit of 35 miles per hour or more.

Unless otherwise specifically stated, all references are as of 2-19-23.

Civil Mental Health Law: A Practical Guide to Virginia Civil Commitment

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A. Hearing Key Concepts.[1]

1. Procedural.

   a. Pettion, Petitioner Notice, Counsel for Respondent, and No Inference of Petitioner's Non-Appearance.[2]

      (i.) Proceedings are commenced with the filing of a petition.[3]

      (ii.) Petitioner must be given adequate notice of the place, date, and time of the commitment hearing.

      (iii.) The petitioner may retain counsel at his own expense and may be present during the hearing, and to testify and present evidence.

      (iv.) The petitioner shall be encouraged but shall not be required to testify at the hearing, and the person whose involuntary admission is sought shall not be released solely on the basis of the petitioner's failure to attend or testify during the hearing.

   b. Community Services Board (CSB).

      (i.) The Court requires the applicable Community Services Board (CSB) to prepare and file a preadmission screening report for the Court.[4]

      (ii.) The applicable CSB is the board serving the county or city where the patient resides or, if impractical, where the patient is located.[5]

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[1] This is a technical treatment of mental health statutes in the writer's state, the Commonwealth of Virginia. For a general overview of the limits and underpinning of the curtailment of liberty by forced treatment process in the United States, please see, *Involuntary Civil Commitment and the Inescapable Wetness of Light*. For an overview of state laws in other jurisdictions, see Treatment Advocacy Center state specific statutes here.

[2] Va. Code § 37.2-814 (F).

[3] Va. Code § 37.2-808 *et seq.* DBHDS Form DC-400110/22 at this link.

[4] Va. Code § 37.2-816. DBHDS preadmission screening report form (2009), at this link.

[5] *Id.*

(iii.) Advance notice of hearing to Community Services Board: minimum 12 hours.[6]

(iv.) Presence of Community Services Board (personal or electronically).[7]

c. Independent Examination and Report.[8]

(i.) Independent examiner duties and certification requirements.[9]

d. Engaged or appointed counsel for patient.[10]

(i.) Counsel's duties.[11]

(ii.) Written description of procedure prior to hearing.[12]

e. Hearing time limits: *72hours±*.[13]

(i.) Hearing for initial treatment.

(a.) The hearing is required after enough time has passed to allow for the examination required by § 37.2-815, preparation of the preadmission screening report required by § 37.2-816, and initiation of mental health treatment to stabilize the person's psychiatric condition to avoid involuntary commitment where possible, but

(b.) must be within 72 hours of the *execution* of a temporary detention order[14] unless the 72-hour period herein ends on a Saturday, Sunday, legal holiday, or

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[6] Va. Code § 37.2-817 B. If the representative of the community services board that prepared the preadmission screening report will be present by telephonic means, the court shall provide the telephone number to the community services board.

[7] *Id.*

[8] Va. Code § 37.2-815. DMHMRSAS Form 1002–IE created by the DBHDS, distributed by Virginia Supreme Court Executive Secretary. Forms, .pdf and print.

[9] Va. Code § 37.2-815

[10] The patient is entitled to counsel, and if none, then appointed counsel. Va. Code § 37.2-814 C. When the patient refuses counsel the writer recommends appointing counsel as an advisor to remain in the hearing and assist as requested. This should be made apparent on the recording required, Va. Code § 37.2-804.2.

[11] During or before the hearing, the attorney *shall* interview his client, the petitioner, the examiner described in § 37.2-815, the community services board staff, and any other material witnesses. He also shall examine all relevant diagnostic and other reports, present evidence and witnesses, if any, on his client's behalf, and otherwise actively represent his client in the proceedings. Va. Code § 37.2-814 (D).

[12] Va. Code § 37.2-814 (D).

[13] Va. Code § 37.2-814 (A).

[14] Va. Code § 37.2-809.

day on which the court is lawfully closed, in which case the person may be detained until the close of business on the next day that is not such a day.[15]

(ii.) Mandatory outpatient treatment (MOT) post discharge treatment.

(a.) A hearing for post discharge mandatory outpatient treatment (MOT) before release from **voluntary treatment <u>in a state hospital</u>** must be held within *72hours±* of a motion filed by the patient's treating physician, family member, personal representative,[16] or the community services board for the state hospital in which the patient volunteered, the patient resides, or where the patient receives treatment, to require the patient to adhere to MOT upon release if the patient at least twice within the 36 months before the date of the hearing has following a hearing voluntarily admitted or been involuntarily admitted to treatment. [17]

(b.) A hearing for post discharge mandatory outpatient treatment (MOT) before release from **involuntary treatment <u>in any hospital</u>** for a patient meeting the same criteria above[18] must be held within the same time frame of the motion filing time, *72hours±*.

f. Place of hearing, mode of participation.

(i.) Place of hearing.[19] The court may convene the hearing at the facility in which the patient is detained or any other place open to the public in the hospital, even though the facility or place is located in a county or city other than his own. A district court judge or special justice of the county or city in which the facility or place is located may conduct the hearing as well.

(ii.) Mode of participation. Hearings, remote or in person.

(a.) Hearings may be conducted electronically when the judge can see the patient and the patient can see the judge.[20]

(b.) When a witness cannot be physically present, testimony may be received using a telephonic communication system.[21]

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[15] For brevity, *72hours±*.

[16] Personal representative is used in several Chapter 8 statutes but not defined except with respect to medical records release for an advance medical directive holder, Va. Code § 37.2-804.2.

[17] Va. Code § 37.2-805.

[18] Va. Code § 37.2-817.01 (C, D).

[19] Va. Code § 37.2-820.

[20] Va. Code § 37.2-801.1 (B).

[21] *Id.*

g. Pretrial release during TDO detention.

(i.) By detention facility.[22] The director of any facility in which the person is detained may release the person prior to a hearing as authorized in §§ 37.2-814 through 37.2-819 if it appears, based on an evaluation conducted by the psychiatrist or clinical psychologist treating the person, that the person would not meet the commitment criteria specified in subsection C of § 37.2-817[23] if released.

(ii.) By court. The Court may release the person on bond on the same grounds.[24]

h. Orders and judgments.

(i.) Service and transmission of petitions and order for initial custody and detention may be made by electronic means.[25]

(ii.) Orders in a proceeding.

(a.) Continuance.

(b.) Dismissal.

(c.) Voluntary status, "VIT."[26]

(iii.) Involuntary treatment.

(a.) Involuntary civil commitment is the last resort. It is ordered only after determining that the patient meets the test for involuntary treatment, but is not willing to volunteer, or capable thereof, and that out-patient treatment is not appropriate.[27]

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[22] Va. Code § 37.2-809 (H) referring to criteria in Va. Code § 37.2-813.

[23] Va. Code § 37.2-817 (C) in pertinent part provides that a person meets the criteria for involuntary treatment if the person " will, in the near future, (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs."

[24] Va. Code § 37.2-813.

[25] Va. Code § 37.2-801.1 (A).

[26] Va. Code § 37.2-814. "Volunteer" is not so simple. When used in Chapter 8 in this chapter, it is a term of art. A "volunteer" cannot simply leave after the hearing: "[t]he judge or special justice *shall* require the volunteer to accept voluntary admission for ***a minimum period of treatment not to exceed*** 72 hours. ***After*** such minimum period of treatment, [***then***] the person shall give the facility 48 hours' notice prior to leaving the facility." Unless the court specifically limits the minimum treatment time the patient is not free to leave (against the wishes of the treating physician) for 120 hours – the initial 72 hours The DBHDS petition for voluntary status, DBHDS 1001B, is at this link. In this work, a patient's acceptance of "voluntary status" after a Ch. 8 hearing is considered voluntary in-hospital treatment, or VIT.

[27] Va. Code § 37.2-817.01 (A).

(b.) The continuum of involuntary mental health treatment is mandatory in-hospital care (MIT) and mandatory out of hospital care (MOT).[28]

Under long considered public policy, in 2022 Virginia involuntary mental health treatment is seen as a continuum.

In order of priority when judicial treatment is required (see test below), first preferred is MOT, then MIT, and then MIT followed by MOT to maintain the patient in the community.

(c.) Place of treatment (MIT).[29] The CSB providing the preadmission screening report designates the treatment facility. If the CSB does not designate a facility at the commitment hearing, the Commissioner of Mental Health facility designates the facility.

(d.) Time limits.

VIT is limited to 72 hours *plus* 48 hour notice to facility.[30]

MIT is initially limited to 30 days. Petitions to extend a term of MIT may be filed at any time prior to the expiration of a term of MIT. Subsequent orders may extend MIT up to 180 days.[31]

MOT commences upon discharge and may be for up to 180 days, and is dependent upon the patient's circumstances in the community.[32]

(e.) MOT details.

- MOT may be ordered *in the initial hearing* if the patient otherwise meets the criteria for involuntary treatment, but the Court finds from a report developed by the CSB screening the patient and other evidence that MOT is appropriate.[33]
- MOT cannot be ordered *in addition to* MIT in the initial hearing or any motion to require MOT post discharge unless there is a history of VIT, MIT or MOT being ordered within the thirty six months preceding the

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[28] Va. Code § 37.2-817.01 (A).

[29] Va. Code § 37.2-817 (C).

[30] Va. Code § 37.2-814 (D).

[31] Va. Code § 37.2-817 (C).

[32] Va. Code § 37.2-817.01 (C)

[33] Va. Code § 37.2-817.01 (B). The Court must find the plan offers an improvement of the patient's condition, that he can adhere to the mandatory outpatient treatment plan, and the ordered treatment will be delivered on an outpatient basis by the community services board or other designated provider. However. the plan is not a "[l]ess restrictive alternative[] … unless the services are actually available in the community.

date of the hearing in which MOT is sought. There are some extensions relating to incarcerated persons in the 36 month period. In this work, this precursor time is referred to as "Countable *P*revious *T*reatment," CPT.[34]

- If CPT is proven in the initial hearing, the Court in the initial hearing can require MOT following discharge form MIT.[35]

2. Incidents of Trial: What Must be Proven, by What Standard, and What are Collateral Consequences?
   a. Clear and convincing standard of proof.[36]
   b. Test for involuntary treatment.[37]
      (i.) "substantial likelihood" that because of
      (ii.)Mental illness the respondent will
      (iii.) In the near future either
         (a.) **Cause serious *physical* harm**
            to himself or
            others
         (b.)as evidenced by relevant information, which may include recent behavior causing, attempting, or threatening harm; or
      (iv.) **Suffer serious harm** [himself] due:
         (a.) to his lack of capacity to protect himself from harm, or
         (b.) to provide for his basic human needs.
   c. Collateral consequences.
      (i.) Firearms restrictions for involuntary and voluntary patients.[38]

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[34] Va. Code § 37.2-817.01 (C).

[35] *Id*. If CPT is proven in the judge or special justice may order that, upon discharge from inpatient treatment, the person adhere to a comprehensive mandatory outpatient treatment plan.

[36] Va. Code § 37.2-817 (C); Va. Code § 37.2-817.01 (B, C).

[37] Va. Code § 37.2-817 (C); Va. Code § 37.2-817.01 (B, C). See *Understanding and Applying Virginia's New Statutory Civil Commitment Criteria*, Cohen, Bonnie, and Monahan (2008).

[38] "It shall be unlawful for any person (i) involuntarily admitted to a facility or ordered to mandatory outpatient treatment pursuant to § 19.2-169.2; (ii) involuntarily admitted to a facility or ordered to mandatory outpatient treatment as the result of a commitment hearing pursuant to Article 5 (§ 37.2-814 et seq.) of Chapter 8 of Title 37.2, notwithstanding the outcome of any appeal taken pursuant to § 37.2-821; (iii) involuntarily admitted to a facility or ordered to mandatory outpatient treatment as a minor 14 years of age or older as the result of a commitment hearing pursuant to Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, notwithstanding the outcome of any appeal taken pursuant to § 16.1-345.6; (iv) who was the subject of a temporary detention order pursuant to § 37.2-809 and

(ii.) The admission of any person to a facility shall not, of itself, create a presumption of legal incapacity.[39]

B. Representing The Petitioner In A Civil Commitment Proceeding.

1. Initial petition[40] filed by a responsible person[41] with the magistrate.[42]
2. Request for Community Services Board in–person evaluation.[43]
3. The prescreening form[44] is a useful checklist / client advocacy tool for counsel to the petitioner.
   a. ¶ 5 contains "buzz words" for presentation to the pre–screener.
   b. ¶ 6 contains reference to the DSM IV listing of mental illness.[45]

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subsequently agreed to voluntary admission pursuant to § 37.2-805; (v) who, as a minor 14 years of age or older, was the subject of a temporary detention order pursuant to § 16.1-340.1 and subsequently agreed to voluntary admission pursuant to § 16.1-338; or (vi) who was found incompetent to stand trial and likely to remain so for the foreseeable future and whose case was disposed of in accordance with § 19.2-169.3, to purchase, possess, or transport a firearm. A violation of this subsection shall be punishable as a Class 1 misdemeanor." Va. Code § 18.2–308.1:3. incorporated in the advice of rights the Court certifies it has provided at the commencement of the hearing, see Form DC 4002 (Order); (https://www.vacourts.gov/courtadmin/aoc/legalresearch/resources/manuals/dcforms/dc4000sadultmentalhealth.pdf) .

[39] Va. Code § 37.2-825. See also Va. Code § 64.2-2000 *et seq.* and provisions relating to guardian's powers pursuant to Va. Code § 64.2-2009 and Va. Code § 37.2-805.1 (B). Analysis, see *Virginia Guardianship and Conservatorship: 2016* (writer's outline).

[40] Form DC-4001 (Petition); (https://www.vacourts.gov/courtadmin/aoc/legalresearch/resources/manuals/dcforms/dc4000sadultmentalhealth.pdf) .

[41] A responsible person includes "a family member as that term is defined in § 37.2-100, a community services board or behavioral health authority, any treating physician of the person, or a law-enforcement officer." Va. Code § 37.2-800. Va. Code § 37.2-100 defines a family member as "an immediate family member of a consumer or the principal caregiver of a consumer. A principal caregiver is a person who acts in the place of an immediate family member, including other relatives and foster care providers, but does not have a proprietary interest in the care of the consumer." Compare, personal representative ambiguity, *supra*.

[42] The "magistrate shall issue [a temporary detention order], upon the sworn petition of any responsible person, treating physician, or upon his own motion and only after an evaluation conducted in-person or [electronically] … by an employee or a designee of the local community services board ..." Va. Code § 37.2-809 B.

[43] *Id.*

[44] See Uniform Preadmission Screening Form (2009).

[45] The "Diagnostic and Statistical Manual of Mental Disorders, 5th Edition,"(DSM-V) published by the American Psychiatric Association. Counsel for Petitioner will do well to understand the mental health professional's praxis language when describing specific behavior when the objective is certification of the case to the magistrate for issuance of a temporary detention order, Va. Code § 37.2-809 (B).

c. ¶ 7 contains sequential risk determination analysis for the pre–screener.

C. Four Cases Often Seen.

1. The schizophrenic.

a. Petitioner is often the parent / spouse / assisted living facility staff.

b. Schizophrenia[46]

(i.) A thought disorder.

(ii.) Symptoms of Schizophrenia typically begin between adolescence and early adulthood for males and a few years later for females, and usually as a result of a stressful period (such as beginning college or starting a first full time job). Initial symptoms may include delusions and hallucinations, disorganized behavior and/or speech. As the disorder progresses symptoms such as flattening or inappropriate affect may develop. Paranoid, catatonic, and undifferentiated types are identified in the DSM.

(iii.) Dangerousness to others (from paranoia) or to themselves (to stop the voices) or unable to care for themselves ("self harm"), in the most extreme form (catatonia).

(iv.) Well treated with medicines which must often be administered involuntarily.

c. A Typical presentation.

5. MENTAL STATUS EXAM (***Check*** all that apply and add specific behaviors under findings)

Appearance: ☐WNL ☑unkempt ☐poor hygiene ☑bizarre ☐tense ☐rigid

Behavior/Motor Disturbance: ☐WNL ☐agitation ☑ guarded ☐tremor ☐manic ☐impulse control ☑ psychomotor retardation

Orientation: WNL **disoriented:** ☑ time ☑ place ☑ person ☐situation

Speech: ☐WNL ☑ pressured ☐slowed ☐soft/loud ☐impoverished ☐slurred ☐other

Mood: ☐WNL ☐depressed ☑ angry/hostile ☐euphoric ☐anxious ☐anhedonic[47] ☐withdrawn

Range of Affect: ☐WNL ☐constricted ☐flat ☑ labile[48] ☐inappropriate

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[46] DSM-V.

[47] Sad. Literally, "without hedonism;" joyless; *ex*., the last man in line at our Sunday morning coffee fellowship, bereft of crumb cake, ruefully sighing as he forks apple slices and carrot sticks, the last morsels on the table.

[48] "[R]eadily or continually undergoing chemical, physical, or biological change or breakdown, **UNSTABLE** <a *labile* mineral> 2 **:** readily open to change" http://www.merriam-webster.com/dictionary/labile.

Unless otherwise specifically stated, all references are as of 2-19-23.

Thought Content: ☐WNL ☑ delusions ☐grandiose ☑ ideas of reference[49] ☑ paranoid ☐obsessions ☐phobias

Thought Process: ☐WNL ☐loose associations ☐flight of ideas ☐circumstantial ☐blocking ☐tangential ☑ perseverative[50]

Perception/ Sensorium: ☐WNL **hallucinations:** ☑ auditory☐ visual ☐olfactory ☐tactile☐ illusions

Memory: ☑ WNL **impaired:** ☐recent ☐remote ☐immediate

Able to provide historical information: Y N If no, explain below in findings.

Appetite: ☑ WNL☐ poor **Weight:** ☐loss ☐gain **Appetite:** ☐increased ☐decreased

Sleep: ☐WNL ☐hypersomnia ☑ onset problem ☑maintenance problem | **Insight:** ☐WNL ☐blaming ☐little☑ none

Judgment: ☐Good ☐impaired ☑ poor

Estimated Intellectual Functioning: ☑ above average ☐average ☐below average ☐diagnosed MR

Reliability of self report (explain below): ☐good ☐fair ☑ poor

Narrative:

Mr. Samuels lives in an assisted living facility. He stopped taking his medicines again.[51] He is hearing voices telling him to kill his roommate, and these are confirmed by the radio. He is afraid to sleep because of the voices; he has not slept in three days. He refuses hospital admission because of the paranoia; he claims his roommate owns the hospital and will have him killed there. He was discharged from ABC Hospital 2 weeks ago.

d. Involuntary judicial consent / forced medication orders.[52]

2. The bi polar.

a. A mood disorder.

(i.) For a diagnosis of Bipolar I disorder, a person must have at least one manic episode. Mania is sometimes referred to as the other extreme to depression. Mania

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[49] The radio is talking *to me* and *not you.*

[50] The tendency to perseveration, the "continuation of something (as repetition of a word) usually to an exceptional degree or beyond a desired point," Merriam-Webster Online Dictionary, http://www.merriam-webster.com/dictionary/perseveration, as in, "Are we there yet?" from the children in the Greyhound seat behind yours. On the way to Texas. In a local.

[51] See ¶ 10, Pre-admission screening ("Has individual followed recommended medication and recovery plan? ☐Y ☐N ☐NA").

[52] Va. Code § 37.2-1101 as limited by –1102 (3).

is an intense high where the person feels euphoric, almost indestructible in areas such as personal finances, business dealings, or relationships. They may have an elevated self-esteem, be more talkative than usual, have flight of ideas, a reduced need for sleep, and be easily distracted. The high, although it may sound appealing, will often lead to severe difficulties in these areas, such as spending much more money than intended, making extremely rash business and personal decisions, involvement in dangerous sexual behavior, and/or the use of drugs or alcohol. Depression is often experienced as the high quickly fades and as the consequences of their activities becomes apparent, the depressive episode can be exacerbated.[53]

b. A typical presentation.

5. MENTAL STATUS EXAM (***Check*** all that apply and add specific behaviors under findings)

Appearance: ☐WNL ☐unkempt ☐poor hygiene ☑ bizarre ☐tense ☐rigid ***Mr. Billings has shaved his head and coated it in black paint.***

Behavior/Motor Disturbance: ☐WNL ☑ agitation ☐guarded ☐tremor ☑manic ☐impulse control ☐psychomotor retardation

Orientation: ☑WNL **disoriented:** ☐time ☐place ☐person ☐situation

Speech: ☐WNL ☑ pressured ☐slowed ☑soft/loud ☐impoverished ☐slurred ☐other

Mood: ☐WNL ☐depressed ☑ angry/hostile ☑ euphoric ☐anxious ☐anhedonic ☐withdrawn

Range of Affect: ☐WNL ☐constricted ☐flat ☑labile ☐inappropriate ***Mr. Billings is alternately loud and louder, more and more expansive and hyper garrulous.***

Thought Content: ☐WNL ☑delusions ☑grandiose ☐ideas of reference ☐paranoid ☐obsessions ☐phobias

Thought Process: ☐WNL ☑ loose associations ☑ flight of ideas ☐circumstantial ☐blocking ☐tangential ☑ perseverative ***Mr. Billings owns this hospital, Richmond Behavioral Health Authority, and several million dollars in stocks. He is fixated on Altria and insists that he should not have been evicted from the Company's headquarters this morning.***

Perception/ Sensorium: ☐WNL **hallucinations:** ☑ auditory☐ visual ☐olfactory ☐tactile☐ illusions

Memory: ☑ WNL **impaired:** ☐recent ☐remote ☐immediate

Able to provide historical information: Y N If no, explain below in findings. ***Could not assess. He would not answer questions (starting with appetite) until I proved that I was not part of the Reynolds***

[53] This is Bi-Polar I type. See here for Bi-Polar II Type.

conspiracy. When I asked about what the conspiracy was about, he said, "I knew you'd play dumb," and asserted his Constitutional rights about discrimination.

Appetite: ☐WNL☐ poor **Weight:** ☐loss ☐gain **Appetite:** ☐increased ☐decreased

Sleep: ☐WNL ☐hypersomnia ☐onset problem ☐maintenance problem | **Insight:** ☐WNL ☐blaming ☐little☐ none

Judgment: ☐Good ☐impaired ☑ poor

Estimated Intellectual Functioning: ☐above average ☑ average ☐below average ☐diagnosed MR

Reliability of self report (explain below): ☐good ☐fair ☑ poor

Narrative*:*

RPD[54] called at 0230 for f-2-f[55] to Philip-Morris site at biotechnology center, Leigh Street. Mr. Billings had altered his appearance by shaving his head and painting his scalp. He knew that there was a conspiracy to keep him from running his business (he claims he was Mr. Morris before he changed his name). He owns everything, etc. He refused to leave the premises to return to his group home. The assisted living facility administrator (John Doakes at 804-xxx-xxxx) reported Mr. Billings had been escalating all day and shouting at the television and other residents who smoked generic cigarettes "and killing my business." He stopped taking his medicine when he was discharged last week from St. Mary's hospital. History of two suicide attempts / one self mutilation (he set himself afire).

c. Involuntary judicial consent / forced medication orders.

3. The schizoaffective. [56]
   a. Schizophrenia and bi–polar in one person.
   b. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia. The major depressive episode must include Criterion A1 : Depressed mood. B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode depressive or manic) during the lifetime duration of the illness. C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness. D. The disturbance is not attributable to the

[54] Richmond Police Department.

[55] Face-to-face ("in-person") assessment, see Va. Code § 37.2-809 (B).

[56] DSM-V.

effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

c. Well controlled by various medicines at address both the delusional and mood components.

d. A typical presentation is a combination of the schizophrenic and bi-polar cases.

4. The alcoholic / drug addict[57]

   a. Serious self harm from physical abuse of the patient's body.

   b. Serious risk to others (chronic d.u.i.)

   c. Terrible risk of death in alcohol withdrawal.[58]

5. The organic patient.

   a. Petitioner is often the child / spouse / nursing home / assisted living facility staff caring for the patient.

   b. Neurocognitive disorders classification.[59]

      (i.) A thought disorder and includes traumatic brain injury.[60]

      (ii.) Symptoms of these disorders often include the root dementia symptoms such as memory loss; trouble naming common items; personality changes; trouble with tasks such as washing dishes or setting the table; wrong dressing for the weather or occasion; careless of hygiene; more argumentative; delusional; wander, often at

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[57] "For the purposes of this chapter, whenever the term mental illness appears, it shall include substance abuse." Va. Code § 37.2-800.

[58] While only between 3- 5% of patients in alcohol withdrawal progress to delirium tremens, the risk of death in *untreated* cases has been estimated at up to 35%. National Institutes of Health, Library of Medicine.

[59] "The neurocognitive disorders (NCDs) (referred to in DSM-IV as "Dementia, Delirium, Amnestic, and Other Cognitive Disorders") begin with delirium, followed by the syndromes of major NCD, mild NCD, and their etiological subtypes. The major or mild NCD subtypes are NCD due to Alzheimer's disease; vascular NCD; NCD with Lewy bodies; NCD due to Parkinson's disease; frontotemporal NCD; NCD due to traumatic brain injury; NCD due to HIV infection; substance/medication-induced NCD; NCD due to Huntington's disease; NCD due to prion disease; NCD due to another medical condition; NCD due to multiple etiologies; and unspecified NCD. The NCD category encompasses the group of disorders in which the primary clinical deficit is in cognitive function, and that are acquired rather than developmental. Although cognitive deficits are present in many if not all mental disorders (e.g., schizophrenia, bipolar disorders), only disorders whose core features are cognitive are included in the NCD category. The NCDs are those in which impaired cognition has not been present since birth or very early life, and thus represents a decline from a previously attained level of functioning."

[60] TBI diagnosis requires that there be "evidence of a traumatic brain injury—that is, an impact to the head or other mechanisms of rapid movement or displacement of the brain within the skull, with one or more of the following: 1. Loss of consciousness. 2. Posttraumatic amnesia. 3. Disorientation and confusion. 4. Neurological signs (e.g., neuroimaging demonstrating injury; a new onset of seizures; a marked worsening of a preexisting seizure disorder; visual field cuts; anosmia; hemiparesis)." DSM-V.

night; depression; difficulty in eating, speaking, family / friend recognition, excretory function, ambulation) punctuated by behavioral issues associated with resulting frustration and confusion.

(iii.) Dangerousness to others (from mistaken identity (*e.g.* sexual assault of "my wife" in "my home" while in a nursing home / assisted living facility, or of assault of third party for "talking with my wife;" in the home, by leaving the stove on) or to themselves (wandering at night, inviting strangers into the home under mistaken belief that they are family) or unable to care for themselves (*e.g.* APS neglect cases,).

(iv.) Not susceptible to remedial medicines but some medicines are available to halt the progress of the disorder.

c. A Typical presentation.

5. MENTAL STATUS EXAM (***Check*** all that apply and add specific behaviors under findings)

Appearance: ☐WNL ☑unkempt ☑ poor hygiene ☑bizarre ☐tense ☐rigid

Behavior/Motor Disturbance: ☐WNL ☑agitation ☐ guarded ☐tremor ☐manic ☐impulse control ☑ psychomotor retardation

Orientation: WNL **disoriented:** ☑ time ☑ place ☑ person ☑ situation

Speech: ☐WNL ☐ pressured ☐slowed ☑ soft/**loud** ☑ impoverished ☐slurred ☐other

Mood: ☐WNL ☐depressed ☑ angry/hostile ☐euphoric ☐anxious ☐anhedonic[61] ☐withdrawn

Range of Affect: ☐WNL ☐constricted ☐flat ☑ labile[62] ☐inappropriate

Thought Content: ☐WNL ☑ delusions ☐grandiose ☑ ideas of reference[63] ☑ paranoid ☐obsessions ☐phobias

Thought Process: ☐WNL ☐loose associations ☐flight of ideas ☐circumstantial ☐blocking ☐tangential ☑ perseverative ***Mrs. Dawson constantly asks me to open the door to let her husband into the room; her husband has been dead for 20 years.***

Perception/ Sensorium: ☑ WNL **hallucinations:** ☐auditory☐ visual ☐olfactory ☐tactile☐ illusions

Memory: ☑ WNL **impaired:** ☐recent ☐remote ☐immediate

Able to provide historical information: Y N If no, explain below in findings.

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[61] See footnote 47, *supra*.

[62] "[R]eadily or continually undergoing chemical, physical, or biological change or breakdown, **UNSTABLE** <a *labile* mineral> 2 **:** readily open to change" http://www.merriam-webster.com/dictionary/labile.

[63] The radio is talking *to me* and *not you.*

Unless otherwise specifically stated, all references are as of 2-19-23.

Appetite: ☐WNL ☑poor **Weight:** ☑ loss ☐gain **Appetite:** ☐increased ☑decreased

Sleep: ☐WNL ☐hypersomnia ☑ onset problem ☑maintenance problem | **Insight:** ☐WNL ☐blaming ☐little☑ none

Judgment: ☐Good ☐impaired ☑ poor

Estimated Intellectual Functioning: ☑ above average ☐average ☐below average ☐diagnosed MR

Reliability of self report (explain below): ☐good ☐fair ☑ poor

Narrative*:*

Mrs. Dawson lives in a nursing home.[64] She was admitted there after her son (John, 70 himself) could no longer care for her in his home. She is hearing her deceased husband's voice asking her to come to the hall, and then out the door. She is restless and can't sleep. She has wandered outside three times. The facility staff's efforts at redirection have been fruitless and last night she struck one of the nurses, drawing blood. She was screaming, "Let my husband in this house now!" She was confused when I met with her and had soiled herself, but refused to let the staff change her diaper.

d. Involuntary judicial consent / forced medication order may not be helpful here.

D. Judicial Consent To Involuntary Treatment.

1. Generally.

   a. Va. Code § 37.2-1101 (A) provides Direct access to *ad hoc* judicial decision making through the District Court.

   b. Ex parte (telephone) consent permitted when the patient incapable of informed consent is in extremis (harm will occur in the next 24 hours) and there is no other decision maker available.[65]

   c. Courts cannot consent to these procedures except as specifically stated:[66]

      1. Nontherapeutic sterilization, abortion, or psychosurgery.

      2. Admission to a training center or a hospital. However, the court may issue an order under § 37.2-1101 authorizing treatment of a person whose admission to a training center or hospital has been or is simultaneously being authorized under §

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[64] Note: if Mrs. Dawson is on Medicaid, she has already been found to require this level of care through the prescreening process required for Medicaid qualification. That process has established she is unable to care for herself or to be cared for in any congregate care facility less intensive than a nursing home. See Va. Medicaid Manual § M 1400, *Long Term Care*.

[65] Va. Code § 54.1-2986 lists the implied surrogates when there is no guardian or advance medical directive holder available. See also Virginia Medical Surrogate Consent (2014).

[66] Va. Code § 37.2-1102.

37.2-805, 37.2-806, 37.2-807, or §§ 37.2-809 through 37.2-813, or of a person who is subject to an order of involuntary admission previously or simultaneously issued under §§ 37.2-814 through 37.2-819 or of Chapter 9 (§ 37.2-900 et seq.).

3. Administration of antipsychotic medication for a period to exceed 180 days or electroconvulsive therapy for a period to exceed 60 days pursuant to any petition filed under this section. The court may authorize electroconvulsive therapy only if it is demonstrated by clear and convincing evidence, which shall include the testimony of a licensed psychiatrist, that all other reasonable forms of treatment have been considered and that electroconvulsive therapy is the most effective treatment for the person. **Even if the court has authorized administration of antipsychotic medication or electroconvulsive therapy hereunder, these treatments may be administered over the person's objection only if he is subject to an order of involuntary admission, including involuntary outpatient treatment, previously or simultaneously issued under §§ 37.2-814 through 37.2-819 or Chapter 9 (§ 37.2-900 et seq.), or the provisions of Chapter 11 (§ 19.2-167 et seq.) or Chapter 11.1 (§ 19.2-182.2 et seq.) of Title 19.2**.
4. Restraint or transportation of the person, unless the court finds upon clear and convincing evidence that restraint or transportation is necessary to the administration of an authorized treatment for a physical disorder or for a mental disorder if the person is subject to an order of involuntary admission issued previously or simultaneously under Chapter 11 (§ 19.2-167 et seq.) or 11.1 (§ 19.2-182.2 et seq.) of Title 19.2, §§ 37.2-814 through 37.2-819, or Chapter 9 (§ 37.2-900 et seq.).

2. Forms.
   a. Emergency, Non-Emergency, and Special Circumstances (Medication, Electroconvulsive Therapy) Forms.[67]
   b. A useful exhibit for the lawyer's expert to consider is a grid with various medicines.[68]
   c. A useful iPhone app for the lawyer (but, judging from at least one review, not for the psychiatrist) is "Psych Drugs," by Michael Quach.[69]

E. Quick Links.

[67] District Court Form DC-489***A*** is a petition for ***NON-EMERGENCY*** consent. District Court Form DC-489 is a petition for ***EMERGENCY*** consent.

[68] National Institute of Mental Health, *Mental Health Medications*. List of psychiatric medications by condition treated (Wikipedia) is a useful lay guide.

[69] See http://itunes.apple.com/us/app/psych-drugs/id330545327?mt=8.

Unless otherwise specifically stated, all references are as of 2-19-23.

1. DBHDS Staff Directory.
2. DBHDS Chapter 8 forms.

Fin.

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.,* 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

LOPER BRIGHT ENTERPRISES ET AL. *v*. RAIMONDO, SECRETARY OF COMMERCE, ET AL.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 22–451. Argued January 17, 2024—Decided June 28, 2024*

The Court granted certiorari in these cases limited to the question whether *Chevron U. S. A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U. S. 837, should be overruled or clarified. Under the *Chevron* doctrine, courts have sometimes been required to defer to "permissible" agency interpretations of the statutes those agencies administer—even when a reviewing court reads the statute differently. *Id.*, at 843. In each case below, the reviewing courts applied *Chevron*'s framework to resolve in favor of the Government challenges by petitioners to a rule promulgated by the National Marine Fisheries Service pursuant to the Magnuson-Stevens Act, 16 U. S. C. §1801 *et seq*., which incorporates the Administrative Procedure Act (APA), 5 U. S. C. §551 *et seq*.

Held: The Administrative Procedure Act requires courts to exercise their independent judgment in deciding whether an agency has acted within its statutory authority, and courts may not defer to an agency interpretation of the law simply because a statute is ambiguous; *Chevron* is overruled. Pp. 7–35.

(a) Article III of the Constitution assigns to the Federal Judiciary the responsibility and power to adjudicate "Cases" and "Controversies"—concrete disputes with consequences for the parties involved. The Framers appreciated that the laws judges would necessarily apply in resolving those disputes would not always be clear, but envisioned

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*Together with No. 22–1219, *Relentless*, *Inc.*, *et al.* v. *Department of Commerce*, *et al.*, on certiorari to the United States Court of Appeals for the First Circuit.

that the final "interpretation of the laws" would be "the proper and peculiar province of the courts." The Federalist No. 78, p. 525 (A. Hamilton). As Chief Justice Marshall declared in the foundational decision of *Marbury* v. *Madison*, "[i]t is emphatically the province and duty of the judicial department to say what the law is." 1 Cranch 137, 177. In the decades following *Marbury*, when the meaning of a statute was at issue, the judicial role was to "interpret the act of Congress, in order to ascertain the rights of the parties." *Decatur* v. *Paulding*, 14 Pet. 497, 515.

The Court recognized from the outset, though, that exercising independent judgment often included according due respect to Executive Branch interpretations of federal statutes. Such respect was thought especially warranted when an Executive Branch interpretation was issued roughly contemporaneously with enactment of the statute and remained consistent over time. The Court also gave "the most respectful consideration" to Executive Branch interpretations simply because "[t]he officers concerned [were] usually able men, and masters of the subject," who may well have drafted the laws at issue. *United States* v. *Moore*, 95 U. S. 760, 763. "Respect," though, was just that. The views of the Executive Branch could inform the judgment of the Judiciary, but did not supersede it. "[I]n cases where [a court's] own judgment . . . differ[ed] from that of other high functionaries," the court was "not at liberty to surrender, or to waive it." *United States* v. *Dickson*, 15 Pet. 141, 162.

During the "rapid expansion of the administrative process" that took place during the New Deal era, *United States* v. *Morton Salt Co.*, 338 U. S. 632, 644, the Court often treated agency determinations of *fact* as binding on the courts, provided that there was "evidence to support the findings," *St. Joseph Stock Yards Co.* v. *United States*, 298 U. S. 38, 51. But the Court did not extend similar deference to agency resolutions of questions of *law*. "The interpretation of the meaning of statutes, as applied to justiciable controversies," remained "exclusively a judicial function." *United States* v. *American Trucking Assns., Inc.*, 310 U. S. 534, 544. The Court also continued to note that the informed judgment of the Executive Branch could be entitled to "great weight." *Id.*, at 549. "The weight of such a judgment in a particular case," the Court observed, would "depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control." *Skidmore* v. *Swift & Co.*, 323 U. S. 134, 140.

Occasionally during this period, the Court applied deferential review after concluding that a particular statute empowered an agency to decide how a broad statutory term applied to specific facts found by

the agency. See *Gray* v. *Powell*, 314 U. S. 402; *NLRB* v. *Hearst Publications, Inc.*, 322 U. S. 111. But such deferential review, which the Court was far from consistent in applying, was cabined to factbound determinations. And the Court did not purport to refashion the longstanding judicial approach to questions of law. It instead proclaimed that "[u]ndoubtedly questions of statutory interpretation . . . are for the courts to resolve, giving appropriate weight to the judgment of those whose special duty is to administer the questioned statute." *Id.*, at 130–131. Nothing in the New Deal era or before it thus resembled the deference rule the Court would begin applying decades later to all varieties of agency interpretations of statutes under *Chevron*. Pp. 7–13.

(b) Congress in 1946 enacted the APA "as a check upon administrators whose zeal might otherwise have carried them to excesses not contemplated in legislation creating their offices." *Morton Salt*, 338 U. S., at 644. The APA prescribes procedures for agency action and delineates the basic contours of judicial review of such action. And it codifies for agency cases the unremarkable, yet elemental proposition reflected by judicial practice dating back to *Marbury*: that courts decide legal questions by applying their own judgment. As relevant here, the APA specifies that courts, not agencies, will decide "*all* relevant questions of law" arising on review of agency action, 5 U. S. C. §706 (emphasis added)—even those involving ambiguous laws. It prescribes no deferential standard for courts to employ in answering those legal questions, despite mandating deferential judicial review of agency policymaking and factfinding. See §§706(2)(A), (E). And by directing courts to "interpret constitutional and statutory provisions" without differentiating between the two, §706, it makes clear that agency interpretations of statutes—like agency interpretations of the Constitution—are *not* entitled to deference. The APA's history and the contemporaneous views of various respected commentators underscore the plain meaning of its text.

Courts exercising independent judgment in determining the meaning of statutory provisions, consistent with the APA, may—as they have from the start—seek aid from the interpretations of those responsible for implementing particular statutes. See *Skidmore*, 323 U. S., at 140. And when the best reading of a statute is that it delegates discretionary authority to an agency, the role of the reviewing court under the APA is, as always, to independently interpret the statute and effectuate the will of Congress subject to constitutional limits. The court fulfills that role by recognizing constitutional delegations, fixing the boundaries of the delegated authority, and ensuring the agency has engaged in " 'reasoned decisionmaking' " within those boundaries. *Michigan* v. *EPA*, 576 U. S. 743, 750 (quoting *Allentown Mack Sales &*

Service, Inc. v. *NLRB*, 522 U. S. 359, 374). By doing so, a court upholds the traditional conception of the judicial function that the APA adopts. Pp. 13–18.

(c) The deference that *Chevron* requires of courts reviewing agency action cannot be squared with the APA. Pp. 18–29.

(1) *Chevron*, decided in 1984 by a bare quorum of six Justices, triggered a marked departure from the traditional judicial approach of independently examining each statute to determine its meaning. The question in the case was whether an Environmental Protection Agency (EPA) regulation was consistent with the term "stationary source" as used in the Clean Air Act. 467 U. S., at 840. To answer that question, the Court articulated and employed a now familiar two-step approach broadly applicable to review of agency action. The first step was to discern "whether Congress ha[d] directly spoken to the precise question at issue." *Id.*, at 842. The Court explained that "[i]f the intent of Congress is clear, that is the end of the matter," *ibid.*, and courts were therefore to "reject administrative constructions which are contrary to clear congressional intent," *id.*, at 843, n. 9. But in a case in which "the statute [was] silent or ambiguous with respect to the specific issue" at hand, a reviewing court could not "simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation." *Id.*, at 843 (footnote omitted). Instead, at *Chevron*'s second step, a court had to defer to the agency if it had offered "a permissible construction of the statute," *ibid.*, even if not "the reading the court would have reached if the question initially had arisen in a judicial proceeding," *ibid.*, n. 11. Employing this new test, the Court concluded that Congress had not addressed the question at issue with the necessary "level of specificity" and that EPA's interpretation was "entitled to deference." *Id.*, at 865.

Although the Court did not at first treat *Chevron* as the watershed decision it was fated to become, the Court and the courts of appeals were soon routinely invoking its framework as the governing standard in cases involving statutory questions of agency authority. The Court eventually decided that *Chevron* rested on "a presumption that Congress, when it left ambiguity in a statute meant for implementation by an agency, understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows." *Smiley* v. *Citibank (South Dakota), N. A.*, 517 U. S. 735, 740–741. Pp. 18–20.

(2) Neither *Chevron* nor any subsequent decision of the Court attempted to reconcile its framework with the APA. *Chevron* defies the command of the APA that "the reviewing court"—not the agency whose

action it reviews—is to "decide *all* relevant questions of law" and "interpret . . . statutory provisions." §706 (emphasis added). It requires a court to *ignore*, not follow, "the reading the court would have reached" had it exercised its independent judgment as required by the APA. *Chevron*, 467 U. S., at 843, n. 11. *Chevron* insists on more than the "respect" historically given to Executive Branch interpretations; it demands that courts mechanically afford *binding* deference to agency interpretations, including those that have been inconsistent over time, see *id.*, at 863, and even when a pre-existing judicial precedent holds that an ambiguous statute means something else, *National Cable & Telecommunications Assn.* v. *Brand X Internet Services*, 545 U. S. 967, 982. That regime is the antithesis of the time honored approach the APA prescribes.

Chevron cannot be reconciled with the APA by presuming that statutory ambiguities are implicit delegations to agencies. That presumption does not approximate reality. A statutory ambiguity does not necessarily reflect a congressional intent that an agency, as opposed to a court, resolve the resulting interpretive question. Many or perhaps most statutory ambiguities may be unintentional. And when courts confront statutory ambiguities in cases that do not involve agency interpretations or delegations of authority, they are not somehow relieved of their obligation to independently interpret the statutes. Instead of declaring a particular party's reading "permissible" in such a case, courts use every tool at their disposal to determine the best reading of the statute and resolve the ambiguity. But in an agency case as in any other, there is a best reading all the same—"the reading the court would have reached" if no agency were involved. *Chevron*, 467 U. S., at 843, n. 11. It therefore makes no sense to speak of a "permissible" interpretation that is not the one the court, after applying all relevant interpretive tools, concludes is best.

Perhaps most fundamentally, *Chevron*'s presumption is misguided because agencies have no special competence in resolving statutory ambiguities. Courts do. The Framers anticipated that courts would often confront statutory ambiguities and expected that courts would resolve them by exercising independent legal judgment. *Chevron* gravely erred in concluding that the inquiry is fundamentally different just because an administrative interpretation is in play. The very point of the traditional tools of statutory construction is to resolve statutory ambiguities. That is no less true when the ambiguity is about the scope of an agency's own power—perhaps the occasion on which abdication in favor of the agency is *least* appropriate. Pp. 21–23.

(3) The Government responds that Congress must generally intend for agencies to resolve statutory ambiguities because agencies have subject matter expertise regarding the statutes they administer;

because deferring to agencies purportedly promotes the uniform construction of federal law; and because resolving statutory ambiguities can involve policymaking best left to political actors, rather than courts. See Brief for Respondents in No. 22–1219, pp. 16–19. But none of these considerations justifies *Chevron*'s sweeping presumption of congressional intent.

As the Court recently noted, interpretive issues arising in connection with a regulatory scheme "may fall more naturally into a judge's bailiwick" than an agency's. *Kisor* v. *Wilkie*, 588 U. S. 558, 578. Under *Chevron*'s broad rule of deference, though, ambiguities of all stripes trigger deference, even in cases having little to do with an agency's technical subject matter expertise. And even when an ambiguity happens to implicate a technical matter, it does not follow that Congress has taken the power to authoritatively interpret the statute from the courts and given it to the agency. Congress expects courts to handle technical statutory questions, and courts did so without issue in agency cases before *Chevron*. After all, in an agency case in particular, the reviewing court will go about its task with the agency's "body of experience and informed judgment," among other information, at its disposal. *Skidmore*, 323 U. S., at 140. An agency's interpretation of a statute "cannot bind a court," but may be especially informative "to the extent it rests on factual premises within [the agency's] expertise." *Bureau of Alcohol, Tobacco and Firearms* v. *FLRA*, 464 U. S. 89, 98, n. 8. Delegating ultimate interpretive authority to agencies is simply not necessary to ensure that the resolution of statutory ambiguities is well informed by subject matter expertise.

Nor does a desire for the uniform construction of federal law justify *Chevron*. It is unclear how much the *Chevron* doctrine as a whole actually promotes such uniformity, and in any event, we see no reason to presume that Congress prefers uniformity for uniformity's sake over the correct interpretation of the laws it enacts.

Finally, the view that interpretation of ambiguous statutory provisions amounts to policymaking suited for political actors rather than courts is especially mistaken because it rests on a profound misconception of the judicial role. Resolution of statutory ambiguities involves legal interpretation, and that task does not suddenly become policymaking just because a court has an "agency to fall back on." *Kisor*, 588 U. S., at 575. Courts interpret statutes, no matter the context, based on the traditional tools of statutory construction, not individual policy preferences. To stay out of discretionary policymaking left to the political branches, judges need only fulfill their obligations under the APA to independently identify and respect such delegations of authority, police the outer statutory boundaries of those delegations, and ensure that agencies exercise their discretion consistent with the APA.

By forcing courts to instead pretend that ambiguities are necessarily delegations, *Chevron* prevents judges from judging. Pp. 23–26.

(4) Because *Chevron*'s justifying presumption is, as Members of the Court have often recognized, a fiction, the Court has spent the better part of four decades imposing one limitation on *Chevron* after another. Confronted with the byzantine set of preconditions and exceptions that has resulted, some courts have simply bypassed *Chevron* or failed to heed its various steps and nuances. The Court, for its part, has not deferred to an agency interpretation under *Chevron* since 2016. But because *Chevron* remains on the books, litigants must continue to wrestle with it, and lower courts—bound by even the Court's crumbling precedents—understandably continue to apply it. At best, *Chevron* has been a distraction from the question that matters: Does the statute authorize the challenged agency action? And at worst, it has required courts to violate the APA by yielding to an agency the express responsibility, vested in "the reviewing *court*," to "decide all relevant questions of law" and "interpret . . . statutory provisions." §706 (emphasis added). Pp. 26–29.

(d) *Stare decisis*, the doctrine governing judicial adherence to precedent, does not require the Court to persist in the *Chevron* project. The *stare decisis* considerations most relevant here—"the quality of [the precedent's] reasoning, the workability of the rule it established, . . . and reliance on the decision," *Knick* v. *Township of Scott*, 588 U. S. 180, 203 (quoting *Janus* v. *State, County, and Municipal Employees*, 585 U. S. 878, 917)—all weigh in favor of letting *Chevron* go.

Chevron has proved to be fundamentally misguided. It reshaped judicial review of agency action without grappling with the APA, the statute that lays out how such review works. And its flaws were apparent from the start, prompting the Court to revise its foundations and continually limit its application.

Experience has also shown that *Chevron* is unworkable. The defining feature of its framework is the identification of statutory ambiguity, but the concept of ambiguity has always evaded meaningful definition. Such an impressionistic and malleable concept "cannot stand as an every-day test for allocating" interpretive authority between courts and agencies. *Swift & Co.* v. *Wickham*, 382 U. S. 111, 125. The Court has also been forced to clarify the doctrine again and again, only adding to *Chevron*'s unworkability, and the doctrine continues to spawn difficult threshold questions that promise to further complicate the inquiry should *Chevron* be retained. And its continuing import is far from clear, as courts have often declined to engage with the doctrine, saying it makes no difference.

Nor has *Chevron* fostered meaningful reliance. Given the Court's constant tinkering with and eventual turn away from *Chevron*, it is

hard to see how anyone could reasonably expect a court to rely on *Chevron* in any particular case or expect it to produce readily foreseeable outcomes. And rather than safeguarding reliance interests, *Chevron* affirmatively destroys them by allowing agencies to change course even when Congress has given them no power to do so.

The only way to "ensure that the law will not merely change erratically, but will develop in a principled and intelligible fashion," *Vasquez* v. *Hillery*, 474 U. S. 254, 265, is for the Court to leave *Chevron* behind. By overruling *Chevron*, though, the Court does not call into question prior cases that relied on the *Chevron* framework. The holdings of those cases that specific agency actions are lawful—including the Clean Air Act holding of *Chevron* itself—are still subject to statutory *stare decisis* despite the Court's change in interpretive methodology. See *CBOCS West, Inc.* v. *Humphries*, 553 U. S. 442, 457. Mere reliance on *Chevron* cannot constitute a "'special justification'" for overruling such a holding. *Halliburton Co.* v. *Erica P. John Fund, Inc.*, 573 U. S. 258, 266 (quoting *Dickerson* v. *United States*, 530 U. S. 428, 443). Pp. 29–35.

No. 22–451, 45 F. 4th 359 & No. 22–1219, 62 F. 4th 621, vacated and remanded.

ROBERTS, C. J., delivered the opinion of the Court, in which THOMAS, ALITO, GORSUCH, KAVANAUGH, and BARRETT, JJ., joined. THOMAS, J., and GORSUCH, J., filed concurring opinions. KAGAN, J., filed a dissenting opinion, in which SOTOMAYOR, J., joined, and in which JACKSON, J., joined as it applies to No. 22–1219. JACKSON, J., took no part in the consideration or decision of the case in No. 22–451.

SUPREME COURT OF THE UNITED STATES

Nos. 22–451 and 22–1219

LOPER BRIGHT ENTERPRISES, ET AL.,
PETITIONERS
22–451 *v.*
GINA RAIMONDO, SECRETARY OF
COMMERCE, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

RELENTLESS, INC., ET AL., PETITIONERS
22–1219 *v.*
DEPARTMENT OF COMMERCE, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

[June 28, 2024]

CHIEF JUSTICE ROBERTS delivered the opinion of the Court.

Since our decision in *Chevron U. S. A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U. S. 837 (1984), we have sometimes required courts to defer to "permissible" agency interpretations of the statutes those agencies administer—even when a reviewing court reads the statute differently. In these cases we consider whether that doctrine should be overruled.

I

Our *Chevron* doctrine requires courts to use a two-step

framework to interpret statutes administered by federal agencies. After determining that a case satisfies the various preconditions we have set for *Chevron* to apply, a reviewing court must first assess "whether Congress has directly spoken to the precise question at issue." *Id.*, at 842. If, and only if, congressional intent is "clear," that is the end of the inquiry. *Ibid.* But if the court determines that "the statute is silent or ambiguous with respect to the specific issue" at hand, the court must, at *Chevron*'s second step, defer to the agency's interpretation if it "is based on a permissible construction of the statute." *Id.*, at 843. The reviewing courts in each of the cases before us applied *Chevron*'s framework to resolve in favor of the Government challenges to the same agency rule.

A

Before 1976, unregulated foreign vessels dominated fishing in the international waters off the U. S. coast, which began just 12 nautical miles offshore. See, *e.g.*, S. Rep. No. 94–459, pp. 2–3 (1975). Recognizing the resultant overfishing and the need for sound management of fishery resources, Congress enacted the Magnuson-Stevens Fishery Conservation and Management Act (MSA). See 90 Stat. 331 (codified as amended at 16 U. S. C. §1801 *et seq*.). The MSA and subsequent amendments extended the jurisdiction of the United States to 200 nautical miles beyond the U. S. territorial sea and claimed "exclusive fishery management authority over all fish" within that area, known as the "exclusive economic zone." §1811(a); see Presidential Proclamation No. 5030, 3 CFR 22 (1983 Comp.); §§101, 102, 90 Stat. 336. The National Marine Fisheries Service (NMFS) administers the MSA under a delegation from the Secretary of Commerce.

The MSA established eight regional fishery management councils composed of representatives from the coastal States, fishery stakeholders, and NMFS. See 16 U. S. C.

§§1852(a), (b). The councils develop fishery management plans, which NMFS approves and promulgates as final regulations. See §§1852(h), 1854(a). In service of the statute's fishery conservation and management goals, see §1851(a), the MSA requires that certain provisions—such as "a mechanism for specifying annual catch limits . . . at a level such that overfishing does not occur," §1853(a)(15)—be included in these plans, see §1853(a). The plans may also include additional discretionary provisions. See §1853(b). For example, plans may "prohibit, limit, condition, or require the use of specified types and quantities of fishing gear, fishing vessels, or equipment," §1853(b)(4); "reserve a portion of the allowable biological catch of the fishery for use in scientific research," §1853(b)(11); and "prescribe such other measures, requirements, or conditions and restrictions as are determined to be necessary and appropriate for the conservation and management of the fishery," §1853(b)(14).

Relevant here, a plan may also require that "one or more observers be carried on board" domestic vessels "for the purpose of collecting data necessary for the conservation and management of the fishery." §1853(b)(8). The MSA specifies three groups that must cover costs associated with observers: (1) foreign fishing vessels operating within the exclusive economic zone (which *must* carry observers), see §§1821(h)(1)(A), (h)(4), (h)(6); (2) vessels participating in certain limited access privilege programs, which impose quotas permitting fishermen to harvest only specific quantities of a fishery's total allowable catch, see §§1802(26), 1853a(c)(1)(H), (e)(2), 1854(d)(2); and (3) vessels within the jurisdiction of the North Pacific Council, where many of the largest and most successful commercial fishing enterprises in the Nation operate, see §1862(a). In the latter two cases, the MSA expressly caps the relevant fees at two or three percent of the value of fish harvested on the vessels. See §§1854(d)(2)(B), 1862(b)(2)(E). And in general, it author-

izes the Secretary to impose "sanctions" when "any payment required for observer services provided to or contracted by an owner or operator . . . has not been paid." §1858(g)(1)(D).

The MSA does not contain similar terms addressing whether Atlantic herring fishermen may be required to bear costs associated with any observers a plan may mandate. And at one point, NMFS fully funded the observer coverage the New England Fishery Management Council required in its plan for the Atlantic herring fishery. See 79 Fed. Reg. 8792 (2014). In 2013, however, the council proposed amending its fishery management plans to empower it to require fishermen to pay for observers if federal funding became unavailable. Several years later, NMFS promulgated a rule approving the amendment. See 85 Fed. Reg. 7414 (2020).

With respect to the Atlantic herring fishery, the Rule created an industry funded program that aims to ensure observer coverage on 50 percent of trips undertaken by vessels with certain types of permits. Under that program, vessel representatives must "declare into" a fishery before beginning a trip by notifying NMFS of the trip and announcing the species the vessel intends to harvest. If NMFS determines that an observer is required, but declines to assign a Government-paid one, the vessel must contract with and pay for a Government-certified third-party observer. NMFS estimated that the cost of such an observer would be up to $710 per day, reducing annual returns to the vessel owner by up to 20 percent. See *id.*, at 7417–7418.

B

Petitioners Loper Bright Enterprises, Inc., H&L Axelsson, Inc., Lund Marr Trawlers LLC, and Scombrus One LLC are family businesses that operate in the Atlantic herring fishery. In February 2020, they challenged the Rule under the MSA, 16 U. S. C. §1855(f), which incorporates

the Administrative Procedure Act (APA), 5 U. S. C. §551 *et seq*. In relevant part, they argued that the MSA does not authorize NMFS to mandate that they pay for observers required by a fishery management plan. The District Court granted summary judgment to the Government. It concluded that the MSA authorized the Rule, but noted that even if these petitioners' "arguments were enough to raise an ambiguity in the statutory text," deference to the agency's interpretation would be warranted under *Chevron*. 544 F. Supp. 3d 82, 107 (DC 2021); see *id.*, at 103–107.

A divided panel of the D. C. Circuit affirmed. See 45 F. 4th 359 (2022). The majority addressed various provisions of the MSA and concluded that it was not "wholly unambiguous" whether NMFS may require Atlantic herring fishermen to pay for observers. *Id.*, at 366. Because there remained "some question" as to Congress's intent, *id.*, at 369, the court proceeded to *Chevron*'s second step and deferred to the agency's interpretation as a "reasonable" construction of the MSA, 45 F. 4th, at 370. In dissent, Judge Walker concluded that Congress's silence on industry funded observers for the Atlantic herring fishery—coupled with the express provision for such observers in other fisheries and on foreign vessels—unambiguously indicated that NMFS lacked the authority to "require [Atlantic herring] fishermen to pay the wages of at-sea monitors." *Id.*, at 375.

C

Petitioners Relentless Inc., Huntress Inc., and Seafreeze Fleet LLC own two vessels that operate in the Atlantic herring fishery: the F/V *Relentless* and the F/V *Persistence*.[1] These vessels use small-mesh bottom-trawl gear and can freeze fish at sea, so they can catch more species of fish and take longer trips than other vessels (about 10 to 14 days, as

[1] For any landlubbers, "F/V" is simply the designation for a fishing vessel.

opposed to the more typical 2 to 4). As a result, they generally declare into multiple fisheries per trip so they can catch whatever the ocean offers up. If the vessels declare into the Atlantic herring fishery for a particular trip, they must carry an observer for that trip if NMFS selects the trip for coverage, even if they end up harvesting fewer herring than other vessels—or no herring at all.

This set of petitioners, like those in the D. C. Circuit case, filed a suit challenging the Rule as unauthorized by the MSA. The District Court, like the D. C. Circuit, deferred to NMFS's contrary interpretation under *Chevron* and thus granted summary judgment to the Government. See 561 F. Supp. 3d 226, 234–238 (RI 2021).

The First Circuit affirmed. See 62 F. 4th 621 (2023). It relied on a "default norm" that regulated entities must bear compliance costs, as well as the MSA's sanctions provision, Section 1858(g)(1)(D). See *id.*, at 629–631. And it rejected petitioners' argument that the express statutory authorization of three industry funding programs demonstrated that NMFS lacked the broad implicit authority it asserted to impose such a program for the Atlantic herring fishery. See *id.*, at 631–633. The court ultimately concluded that the "[a]gency's interpretation of its authority to require at-sea monitors who are paid for by owners of regulated vessels does not 'exceed[] the bounds of the permissible.'" *Id.*, at 633–634 (quoting *Barnhart* v. *Walton*, 535 U. S. 212, 218 (2002); alteration in original). In reaching that conclusion, the First Circuit stated that it was applying *Chevron*'s two-step framework. 62 F. 4th, at 628. But it did not explain which aspects of its analysis were relevant to which of *Chevron*'s two steps. Similarly, it declined to decide whether the result was "a product of *Chevron* step one or step two." *Id.*, at 634.

We granted certiorari in both cases, limited to the question whether *Chevron* should be overruled or clarified. See

601 U. S. ___ (2023); 598 U. S. ___ (2023).[2]

II

A

Article III of the Constitution assigns to the Federal Judiciary the responsibility and power to adjudicate "Cases" and "Controversies"—concrete disputes with consequences for the parties involved. The Framers appreciated that the laws judges would necessarily apply in resolving those disputes would not always be clear. Cognizant of the limits of human language and foresight, they anticipated that "[a]ll new laws, though penned with the greatest technical skill, and passed on the fullest and most mature deliberation," would be "more or less obscure and equivocal, until their meaning" was settled "by a series of particular discussions and adjudications." The Federalist No. 37, p. 236 (J. Cooke ed. 1961) (J. Madison).

The Framers also envisioned that the final "interpretation of the laws" would be "the proper and peculiar province of the courts." *Id.*, No. 78, at 525 (A. Hamilton). Unlike the political branches, the courts would by design exercise "neither Force nor Will, but merely judgment." *Id.*, at 523. To ensure the "steady, upright and impartial administration of the laws," the Framers structured the Constitution to allow judges to exercise that judgment independent of influence from the political branches. *Id.*, at 522; see *id.*, at 522–524; *Stern* v. *Marshall*, 564 U. S. 462, 484 (2011).

This Court embraced the Framers' understanding of the judicial function early on. In the foundational decision of *Marbury* v. *Madison*, Chief Justice Marshall famously declared that "[i]t is emphatically the province and duty of the judicial department to say what the law is." 1 Cranch 137,

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[2] Both petitions also presented questions regarding the consistency of the Rule with the MSA. See Pet. for Cert. in No. 22–451, p. i; Pet. for Cert. in No. 22–1219, p. ii. We did not grant certiorari with respect to those questions and thus do not reach them.

177 (1803). And in the following decades, the Court understood "interpret[ing] the laws, in the last resort," to be a "solemn duty" of the Judiciary. *United States* v. *Dickson*, 15 Pet. 141, 162 (1841) (Story, J., for the Court). When the meaning of a statute was at issue, the judicial role was to "interpret the act of Congress, in order to ascertain the rights of the parties." *Decatur* v. *Paulding*, 14 Pet. 497, 515 (1840).

The Court also recognized from the outset, though, that exercising independent judgment often included according due respect to Executive Branch interpretations of federal statutes. For example, in *Edwards' Lessee* v. *Darby*, 12 Wheat. 206 (1827), the Court explained that "[i]n the construction of a doubtful and ambiguous law, the contemporaneous construction of those who were called upon to act under the law, and were appointed to carry its provisions into effect, is entitled to very great respect." *Id.*, at 210; see also *United States* v. *Vowell*, 5 Cranch 368, 372 (1809) (Marshall, C. J., for the Court).

Such respect was thought especially warranted when an Executive Branch interpretation was issued roughly contemporaneously with enactment of the statute and remained consistent over time. See *Dickson*, 15 Pet., at 161; *United States* v. *Alabama Great Southern R. Co.*, 142 U. S. 615, 621 (1892); *National Lead Co.* v. *United States*, 252 U. S. 140, 145–146 (1920). That is because "the longstanding 'practice of the government'"—like any other interpretive aid—"can inform [a court's] determination of 'what the law is.'" *NLRB* v. *Noel Canning*, 573 U. S. 513, 525 (2014) (first quoting *McCulloch* v. *Maryland*, 4 Wheat. 316, 401 (1819); then quoting *Marbury*, 1 Cranch, at 177). The Court also gave "the most respectful consideration" to Executive Branch interpretations simply because "[t]he officers concerned [were] usually able men, and masters of the subject," who were "[n]ot unfrequently . . . the draftsmen of the laws they [were] afterwards called upon to interpret." *United*

States v. *Moore*, 95 U. S. 760, 763 (1878); see also *Jacobs* v. *Prichard*, 223 U. S. 200, 214 (1912).

"Respect," though, was just that. The views of the Executive Branch could inform the judgment of the Judiciary, but did not supersede it. Whatever respect an Executive Branch interpretation was due, a judge "certainly would not be bound to adopt the construction given by the head of a department." *Decatur*, 14 Pet., at 515; see also *Burnet* v. *Chicago Portrait Co.*, 285 U. S. 1, 16 (1932). Otherwise, judicial judgment would not be independent at all. As Justice Story put it, "in cases where [a court's] own judgment . . . differ[ed] from that of other high functionaries," the court was "not at liberty to surrender, or to waive it." *Dickson*, 15 Pet., at 162.

B

The New Deal ushered in a "rapid expansion of the administrative process." *United States* v. *Morton Salt Co.*, 338 U. S. 632, 644 (1950). But as new agencies with new powers proliferated, the Court continued to adhere to the traditional understanding that questions of law were for courts to decide, exercising independent judgment.

During this period, the Court often treated agency determinations of *fact* as binding on the courts, provided that there was "evidence to support the findings." *St. Joseph Stock Yards Co.* v. *United States*, 298 U. S. 38, 51 (1936). "When the legislature itself acts within the broad field of legislative discretion," the Court reasoned, "its determinations are conclusive." *Ibid.* Congress could therefore "appoint[] an agent to act within that sphere of legislative authority" and "endow the agent with power to make *findings of fact* which are conclusive, provided the requirements of due process which are specially applicable to such an agency are met, as in according a fair hearing and acting upon evidence and not arbitrarily." *Ibid.* (emphasis added).

But the Court did not extend similar deference to agency

resolutions of questions of *law*. It instead made clear, repeatedly, that "[t]he interpretation of the meaning of statutes, as applied to justiciable controversies," was "exclusively a judicial function." *United States* v. *American Trucking Assns., Inc.*, 310 U. S. 534, 544 (1940); see also *Social Security Bd.* v. *Nierotko*, 327 U. S. 358, 369 (1946); *Medo Photo Supply Corp.* v. *NLRB*, 321 U. S. 678, 681–682, n. 1 (1944). The Court understood, in the words of Justice Brandeis, that "[t]he supremacy of law demands that there shall be opportunity to have some court decide whether an erroneous rule of law was applied." *St. Joseph Stock Yards*, 298 U. S., at 84 (concurring opinion). It also continued to note, as it long had, that the informed judgment of the Executive Branch—especially in the form of an interpretation issued contemporaneously with the enactment of the statute—could be entitled to "great weight." *American Trucking Assns.*, 310 U. S., at 549.

Perhaps most notably along those lines, in *Skidmore* v. *Swift & Co.*, 323 U. S. 134 (1944), the Court explained that the "interpretations and opinions" of the relevant agency, "made in pursuance of official duty" and "based upon . . . specialized experience," "constitute[d] a body of experience and informed judgment to which courts and litigants [could] properly resort for guidance," even on legal questions. *Id.*, at 139–140. "The weight of such a judgment in a particular case," the Court observed, would "depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control." *Id.*, at 140.

On occasion, to be sure, the Court applied deferential review upon concluding that a particular statute empowered an agency to decide how a broad statutory term applied to specific facts found by the agency. For example, in *Gray* v. *Powell*, 314 U. S. 402 (1941), the Court deferred to an administrative conclusion that a coal-burning railroad that

had arrangements with several coal mines was not a coal "producer" under the Bituminous Coal Act of 1937. Congress had "specifically" granted the agency the authority to make that determination. *Id.*, at 411. The Court thus reasoned that "[w]here, as here, a determination has been left to an administrative body, this delegation will be respected and the administrative conclusion left untouched" so long as the agency's decision constituted "a sensible exercise of judgment." *Id.*, at 412–413. Similarly, in *NLRB* v. *Hearst Publications, Inc.*, 322 U. S. 111 (1944), the Court deferred to the determination of the National Labor Relations Board that newsboys were "employee[s]" within the meaning of the National Labor Relations Act. The Act had, in the Court's judgment, "assigned primarily" to the Board the task of marking a "definitive limitation around the term 'employee.'" *Id.*, at 130. The Court accordingly viewed its own role as "limited" to assessing whether the Board's determination had a "'warrant in the record' and a reasonable basis in law." *Id.*, at 131.

Such deferential review, though, was cabined to fact-bound determinations like those at issue in *Gray* and *Hearst*. Neither *Gray* nor *Hearst* purported to refashion the longstanding judicial approach to questions of law. In *Gray*, after deferring to the agency's determination that a particular entity was not a "producer" of coal, the Court went on to discern, based on its own reading of the text, whether another statutory term—"other disposal" of coal—encompassed a transaction lacking a transfer of title. See 314 U. S., at 416–417. The Court evidently perceived no basis for deference to the agency with respect to that pure legal question. And in *Hearst*, the Court proclaimed that "[u]ndoubtedly questions of statutory interpretation . . . are for the courts to resolve, giving appropriate weight to the judgment of those whose special duty is to administer the questioned statute." 322 U. S., at 130–131. At least with

respect to questions it regarded as involving "statutory interpretation," the Court thus did not disturb the traditional rule. It merely thought that a different approach should apply where application of a statutory term was sufficiently intertwined with the agency's factfinding.

In any event, the Court was far from consistent in reviewing deferentially even such factbound statutory determinations. Often the Court simply interpreted and applied the statute before it. See K. Davis, Administrative Law §248, p. 893 (1951) ("The one statement that can be made with confidence about applicability of the doctrine of Gray v. Powell is that sometimes the Supreme Court applies it and sometimes it does not."); B. Schwartz, Gray vs. Powell and the Scope of Review, 54 Mich. L. Rev. 1, 68 (1955) (noting an "embarrassingly large number of Supreme Court decisions that do not adhere to the doctrine of *Gray v. Powell*"). In one illustrative example, the Court rejected the U. S. Price Administrator's determination that a particular warehouse was a "public utility" entitled to an exemption from the Administrator's General Maximum Price Regulation. Despite the striking resemblance of that administrative determination to those that triggered deference in *Gray* and *Hearst*, the Court declined to "accept the Administrator's view in deference to administrative construction." *Davies Warehouse Co.* v. *Bowles*, 321 U. S. 144, 156 (1944). The Administrator's view, the Court explained, had "hardly seasoned or broadened into a settled administrative practice," and thus did not "overweigh the considerations" the Court had "set forth as to the proper construction of the statute." *Ibid.*

Nothing in the New Deal era or before it thus resembled the deference rule the Court would begin applying decades later to all varieties of agency interpretations of statutes. Instead, just five years after *Gray* and two after *Hearst*, Congress codified the opposite rule: the traditional understanding that *courts* must "decide all relevant questions of

law." 5 U. S. C. §706.[3]

C

Congress in 1946 enacted the APA "as a check upon administrators whose zeal might otherwise have carried them to excesses not contemplated in legislation creating their offices." *Morton Salt*, 338 U. S., at 644. It was the culmination of a "comprehensive rethinking of the place of administrative agencies in a regime of separate and divided powers." *Bowen* v. *Michigan Academy of Family Physicians*, 476 U. S. 667, 670–671 (1986).

In addition to prescribing procedures for agency action, the APA delineates the basic contours of judicial review of such action. As relevant here, Section 706 directs that "[t]o

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[3]The dissent plucks out *Gray*, *Hearst*, and—to "gild the lily," in its telling—three more 1940s decisions, claiming they reflect the relevant historical tradition of judicial review. *Post*, at 21–22, and n. 6 (opinion of KAGAN, J.). But it has no substantial response to the fact that *Gray* and *Hearst* themselves endorsed, implicitly in one case and explicitly in the next, the traditional rule that "questions of statutory interpretation . . . are for the courts to resolve, giving appropriate weight"—not outright deference—"to the judgment of those whose special duty is to administer the questioned statute." *Hearst*, 322 U. S., at 130–131. And it fails to recognize the deep roots that this rule has in our Nation's judicial tradition, to the limited extent it engages with that tradition at all. See *post*, at 20–21, n. 5. Instead, like the Government, it strains to equate the "respect" or "weight" traditionally afforded to Executive Branch interpretations with binding deference. See *ibid.*; Brief for Respondents in No. 22–1219, pp. 21–24. That supposed equivalence is a fiction. The dissent's cases establish that a "*contemporaneous* construction" shared by "not *only* . . . the courts" but also "the departments" could be "controlling," *Schell's Executors* v. *Fauché*, 138 U. S. 562, 572 (1891) (emphasis added), and that courts might "lean in favor" of a "contemporaneous" and "continued" construction of the Executive Branch as strong evidence of a statute's meaning, *United States* v. *Alabama Great Southern R. Co.*, 142 U. S. 615, 621 (1892). They do not establish that Executive Branch interpretations of ambiguous statutes—no matter how inconsistent, late breaking, or flawed—always *bound* the courts. In reality, a judge was never "bound to adopt the construction given by the head of a department." *Decatur* v. *Paulding*, 14 Pet. 497, 515 (1840).

the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action." 5 U. S. C. §706. It further requires courts to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . not in accordance with law." §706(2)(A).

The APA thus codifies for agency cases the unremarkable, yet elemental proposition reflected by judicial practice dating back to *Marbury*: that courts decide legal questions by applying their own judgment. It specifies that courts, not agencies, will decide "*all* relevant questions of law" arising on review of agency action, §706 (emphasis added)—even those involving ambiguous laws—and set aside any such action inconsistent with the law as they interpret it. And it prescribes no deferential standard for courts to employ in answering those legal questions. That omission is telling, because Section 706 *does* mandate that judicial review of agency policymaking and factfinding be deferential. See §706(2)(A) (agency action to be set aside if "arbitrary, capricious, [or] an abuse of discretion"); §706(2)(E) (agency factfinding in formal proceedings to be set aside if "unsupported by substantial evidence").

In a statute designed to "serve as the fundamental charter of the administrative state," *Kisor* v. *Wilkie*, 588 U. S. 558, 580 (2019) (plurality opinion) (internal quotation marks omitted), Congress surely would have articulated a similarly deferential standard applicable to questions of law had it intended to depart from the settled pre-APA understanding that deciding such questions was "exclusively a judicial function," *American Trucking Assns.*, 310 U. S., at 544. But nothing in the APA hints at such a dramatic departure. On the contrary, by directing courts to "interpret constitutional and statutory provisions" without differentiating between the two, Section 706 makes clear that

agency interpretations of statutes—like agency interpretations of the Constitution—are *not* entitled to deference. Under the APA, it thus "remains the responsibility of the court to decide whether the law means what the agency says." *Perez* v. *Mortgage Bankers Assn.*, 575 U. S. 92, 109 (2015) (Scalia, J., concurring in judgment).[4]

The text of the APA means what it says. And a look at its history if anything only underscores that plain meaning. According to both the House and Senate Reports on the legislation, Section 706 "provide[d] that questions of law are for courts *rather than agencies* to decide in the last analysis." H. R. Rep. No. 1980, 79th Cong., 2d Sess., 44 (1946) (emphasis added); accord, S. Rep. No. 752, 79th Cong., 1st Sess., 28 (1945). Some of the legislation's most prominent supporters articulated the same view. See 92 Cong. Rec. 5654 (1946) (statement of Rep. Walter); P. McCarran, Improving "Administrative Justice": Hearings and Evidence; Scope of Judicial Review, 32 A. B. A. J. 827, 831 (1946). Even the Department of Justice—an agency with every incentive to endorse a view of the APA favorable to the Executive Branch—opined after its enactment that Section 706 merely "restate[d] the present law as to the scope of judicial review." Dept. of Justice, Attorney General's Manual on the

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[4]The dissent observes that Section 706 does not say expressly that courts are to decide legal questions using "a *de novo* standard of review." *Post*, at 16. That much is true. But statutes can be sensibly understood only "by reviewing text in context." *Pulsifer* v. *United States*, 601 U. S. 124, 133 (2024). Since the start of our Republic, courts have "decide[d] . . . questions of law" and "interpret[ed] constitutional and statutory provisions" by applying their own legal judgment. §706. Setting aside its misplaced reliance on *Gray* and *Hearst*, the dissent does not and could not deny that tradition. But it nonetheless insists that to codify that tradition, Congress needed to expressly reject a sort of deference the courts had never before applied—and would not apply for several decades to come. It did not. "The notion that some things 'go without saying' applies to legislation just as it does to everyday life." *Bond* v. *United States*, 572 U. S. 844, 857 (2014).

Administrative Procedure Act 108 (1947); see also *Kisor*, 588 U. S., at 582 (plurality opinion) (same). That "present law," as we have described, adhered to the traditional conception of the judicial function. See *supra*, at 9–13.

Various respected commentators contemporaneously maintained that the APA required reviewing courts to exercise independent judgment on questions of law. Professor John Dickinson, for example, read the APA to "impose a clear mandate that all [questions of law] shall be decided by the reviewing Court itself, and in the exercise of its own independent judgment." Administrative Procedure Act: Scope and Grounds of Broadened Judicial Review, 33 A. B. A. J. 434, 516 (1947). Professor Bernard Schwartz noted that §706 "would seem . . . to be merely a legislative restatement of the familiar review principle that questions of law are for the reviewing court, at the same time leaving to the courts the task of determining in each case what are questions of law." Mixed Questions of Law and Fact and the Administrative Procedure Act, 19 Ford. L. Rev. 73, 84–85 (1950). And Professor Louis Jaffe, who had served in several agencies at the advent of the New Deal, thought that §706 leaves it up to the reviewing "court" to "decide as a 'question of law' whether there is 'discretion' in the premises"—that is, whether the statute at issue delegates particular discretionary authority to an agency. Judicial Control of Administrative Action 570 (1965).

The APA, in short, incorporates the traditional understanding of the judicial function, under which courts must exercise independent judgment in determining the meaning of statutory provisions. In exercising such judgment, though, courts may—as they have from the start—seek aid from the interpretations of those responsible for implementing particular statutes. Such interpretations "constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance" consistent with the APA. *Skidmore*, 323 U. S., at 140. And

interpretations issued contemporaneously with the statute at issue, and which have remained consistent over time, may be especially useful in determining the statute's meaning. See *ibid.*; *American Trucking Assns.*, 310 U. S., at 549.

In a case involving an agency, of course, the statute's meaning may well be that the agency is authorized to exercise a degree of discretion. Congress has often enacted such statutes. For example, some statutes "expressly delegate[]" to an agency the authority to give meaning to a particular statutory term. *Batterton* v. *Francis*, 432 U. S. 416, 425 (1977) (emphasis deleted).[5] Others empower an agency to prescribe rules to "fill up the details" of a statutory scheme, *Wayman* v. *Southard*, 10 Wheat. 1, 43 (1825), or to regulate subject to the limits imposed by a term or phrase that "leaves agencies with flexibility," *Michigan* v. *EPA*, 576 U. S. 743, 752 (2015), such as "appropriate" or "reasonable."[6]

When the best reading of a statute is that it delegates

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[5] See, *e.g.*, 29 U. S. C. §213(a)(15) (exempting from provisions of the Fair Labor Standards Act "any employee employed on a casual basis in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves (*as such terms are defined and delimited by regulations of the Secretary*)" (emphasis added)); 42 U. S. C. §5846(a)(2) (requiring notification to Nuclear Regulatory Commission when a facility or activity licensed or regulated pursuant to the Atomic Energy Act "contains a defect which could create a substantial safety hazard, *as defined by regulations which the Commission shall promulgate*" (emphasis added)).

[6] See, *e.g.*, 33 U. S. C. §1312(a) (requiring establishment of effluent limitations "[w]henever, in the judgment of the [Environmental Protection Agency (EPA)] Administrator . . . , discharges of pollutants from a point source or group of point sources . . . would interfere with the attainment or maintenance of that water quality . . . which shall assure" various outcomes, such as the "protection of public health" and "public water supplies"); 42 U. S. C. §7412(n)(1)(A) (directing EPA to regulate power plants "if the Administrator finds such regulation is appropriate and necessary").

discretionary authority to an agency, the role of the reviewing court under the APA is, as always, to independently interpret the statute and effectuate the will of Congress subject to constitutional limits. The court fulfills that role by recognizing constitutional delegations, "fix[ing] the boundaries of [the] delegated authority," H. Monaghan, *Marbury* and the Administrative State, 83 Colum. L. Rev. 1, 27 (1983), and ensuring the agency has engaged in "'reasoned decisionmaking'" within those boundaries, *Michigan*, 576 U. S., at 750 (quoting *Allentown Mack Sales & Service, Inc.* v. *NLRB*, 522 U. S. 359, 374 (1998)); see also *Motor Vehicle Mfrs. Assn. of United States, Inc.* v. *State Farm Mut. Automobile Ins. Co.*, 463 U. S. 29 (1983). By doing so, a court upholds the traditional conception of the judicial function that the APA adopts.

III

The deference that *Chevron* requires of courts reviewing agency action cannot be squared with the APA.

A

In the decades between the enactment of the APA and this Court's decision in *Chevron*, courts generally continued to review agency interpretations of the statutes they administer by independently examining each statute to determine its meaning. Cf. T. Merrill, Judicial Deference to Executive Precedent, 101 Yale L. J. 969, 972–975 (1992). As an early proponent (and later critic) of *Chevron* recounted, courts during this period thus identified delegations of discretionary authority to agencies on a "statute-by-statute basis." A. Scalia, Judicial Deference to Administrative Interpretations of Law, 1989 Duke L. J. 511, 516.

Chevron, decided in 1984 by a bare quorum of six Justices, triggered a marked departure from the traditional approach. The question in the case was whether an EPA regulation "allow[ing] States to treat all of the pollution-

emitting devices within the same industrial grouping as though they were encased within a single 'bubble'" was consistent with the term "stationary source" as used in the Clean Air Act. 467 U. S., at 840. To answer that question of statutory interpretation, the Court articulated and employed a now familiar two-step approach broadly applicable to review of agency action.

The first step was to discern "whether Congress ha[d] directly spoken to the precise question at issue." *Id.*, at 842. The Court explained that "[i]f the intent of Congress is clear, that is the end of the matter," *ibid.*, and courts were therefore to "reject administrative constructions which are contrary to clear congressional intent," *id.*, at 843, n. 9. To discern such intent, the Court noted, a reviewing court was to "employ[] traditional tools of statutory construction." *Ibid.*

Without mentioning the APA, or acknowledging any doctrinal shift, the Court articulated a second step applicable when "Congress ha[d] not directly addressed the precise question at issue." *Id.*, at 843. In such a case—that is, a case in which "the statute [was] silent or ambiguous with respect to the specific issue" at hand—a reviewing court could not "simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation." *Ibid.* (footnote omitted). A court instead had to set aside the traditional interpretive tools and defer to the agency if it had offered "a permissible construction of the statute," *ibid.*, even if not "the reading the court would have reached if the question initially had arisen in a judicial proceeding," *ibid.*, n. 11. That directive was justified, according to the Court, by the understanding that administering statutes "requires the formulation of policy" to fill statutory "gap[s]"; by the long judicial tradition of according "considerable weight" to Executive Branch interpretations; and by a host of other considerations, including the complexity of the regulatory scheme, EPA's "detailed

and reasoned" consideration, the policy-laden nature of the judgment supposedly required, and the agency's indirect accountability to the people through the President. *Id.*, at 843, 844, and n. 14, 865.

Employing this new test, the Court concluded that Congress had not addressed the question at issue with the necessary "level of specificity" and that EPA's interpretation was "entitled to deference." *Id.*, at 865. It did not matter *why* Congress, as the Court saw it, had not squarely addressed the question, see *ibid.*, or that "the agency ha[d] from time to time changed its interpretation," *id.*, at 863. The latest EPA interpretation was a permissible reading of the Clean Air Act, so under the Court's new rule, that reading controlled.

Initially, *Chevron* "seemed destined to obscurity." T. Merrill, The Story of *Chevron*: The Making of an Accidental Landmark, 66 Admin. L. Rev. 253, 276 (2014). The Court did not at first treat it as the watershed decision it was fated to become; it was hardly cited in cases involving statutory questions of agency authority. See *ibid.* But within a few years, both this Court and the courts of appeals were routinely invoking its two-step framework as the governing standard in such cases. See *id.*, at 276–277. As the Court did so, it revisited the doctrine's justifications. Eventually, the Court decided that *Chevron* rested on "a presumption that Congress, when it left ambiguity in a statute meant for implementation by an agency, understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows." *Smiley* v. *Citibank (South Dakota), N. A.*, 517 U. S. 735, 740–741 (1996); see also, *e.g.*, *Cuozzo Speed Technologies, LLC* v. *Lee*, 579 U. S. 261, 276–277 (2016); *Utility Air Regulatory Group* v. *EPA*, 573 U. S. 302, 315 (2014); *National Cable & Telecommunications Assn.* v. *Brand X Internet Services*, 545 U. S. 967, 982 (2005).

B

Neither *Chevron* nor any subsequent decision of this Court attempted to reconcile its framework with the APA. The "law of deference" that this Court has built on the foundation laid in *Chevron* has instead been "[h]eedless of the original design" of the APA. *Perez*, 575 U. S., at 109 (Scalia, J., concurring in judgment).

1

Chevron defies the command of the APA that "the reviewing court"—not the agency whose action it reviews—is to "decide *all* relevant questions of law" and "interpret . . . statutory provisions." §706 (emphasis added). It requires a court to *ignore*, not follow, "the reading the court would have reached" had it exercised its independent judgment as required by the APA. *Chevron*, 467 U. S., at 843, n. 11. And although exercising independent judgment is consistent with the "respect" historically given to Executive Branch interpretations, see, *e.g.*, *Edwards' Lessee*, 12 Wheat., at 210; *Skidmore*, 323 U. S., at 140, *Chevron* insists on much more. It demands that courts mechanically afford *binding* deference to agency interpretations, including those that have been inconsistent over time. See 467 U. S., at 863. Still worse, it forces courts to do so even when a pre-existing judicial precedent holds that the statute means something else—unless the prior court happened to also say that the statute is "unambiguous." *Brand X*, 545 U. S., at 982. That regime is the antithesis of the time honored approach the APA prescribes. In fretting over the prospect of "allow[ing]" a judicial interpretation of a statute "to override an agency's" in a dispute before a court, *ibid.*, *Chevron* turns the statutory scheme for judicial review of agency action upside down.

Chevron cannot be reconciled with the APA, as the Government and the dissent contend, by presuming that statutory ambiguities are implicit delegations to agencies. See

Brief for Respondents in No. 22–1219, pp. 13, 37–38; *post*, at 4–15 (opinion of KAGAN, J.). Presumptions have their place in statutory interpretation, but only to the extent that they approximate reality. *Chevron*'s presumption does not, because "[a]n ambiguity is simply not a delegation of law-interpreting power. *Chevron* confuses the two." C. Sunstein, Interpreting Statutes in the Regulatory State, 103 Harv. L. Rev. 405, 445 (1989). As *Chevron* itself noted, ambiguities may result from an inability on the part of Congress to squarely answer the question at hand, or from a failure to even "consider the question" with the requisite precision. 467 U. S., at 865. In neither case does an ambiguity necessarily reflect a congressional intent that an agency, as opposed to a court, resolve the resulting interpretive question. And many or perhaps most statutory ambiguities may be unintentional. As the Framers recognized, ambiguities will inevitably follow from "the complexity of objects, . . . the imperfection of the human faculties," and the simple fact that "no language is so copious as to supply words and phrases for every complex idea." The Federalist No. 37, at 236.

Courts, after all, routinely confront statutory ambiguities in cases having nothing to do with *Chevron*—cases that do not involve agency interpretations or delegations of authority. Of course, when faced with a statutory ambiguity in such a case, the ambiguity is not a delegation to anybody, and a court is not somehow relieved of its obligation to independently interpret the statute. Courts in that situation do not throw up their hands because "Congress's instructions have" supposedly "run out," leaving a statutory "gap." *Post*, at 2 (opinion of KAGAN, J.). Courts instead understand that such statutes, no matter how impenetrable, do—in fact, must—have a single, best meaning. That is the whole point of having written statutes; "every statute's meaning is fixed at the time of enactment." *Wisconsin Cen-*

tral Ltd. v. *United States*, 585 U. S. 274, 284 (2018) (emphasis deleted). So instead of declaring a particular party's reading "permissible" in such a case, courts use every tool at their disposal to determine the best reading of the statute and resolve the ambiguity.

In an agency case as in any other, though, even if some judges might (or might not) consider the statute ambiguous, there is a best reading all the same—"the reading the court would have reached" if no agency were involved. *Chevron*, 467 U. S., at 843, n. 11. It therefore makes no sense to speak of a "permissible" interpretation that is not the one the court, after applying all relevant interpretive tools, concludes is best. In the business of statutory interpretation, if it is not the best, it is not permissible.

Perhaps most fundamentally, *Chevron*'s presumption is misguided because agencies have no special competence in resolving statutory ambiguities. Courts do. The Framers, as noted, anticipated that courts would often confront statutory ambiguities and expected that courts would resolve them by exercising independent legal judgment. And even *Chevron* itself reaffirmed that "[t]he judiciary is the final authority on issues of statutory construction" and recognized that "in the absence of an administrative interpretation," it is "necessary" for a court to "impose its own construction on the statute." *Id.*, at 843, and n. 9. *Chevron* gravely erred, though, in concluding that the inquiry is fundamentally different just because an administrative interpretation is in play. The very point of the traditional tools of statutory construction—the tools courts use every day—is to resolve statutory ambiguities. That is no less true when the ambiguity is about the scope of an agency's own power—perhaps the occasion on which abdication in favor of the agency is *least* appropriate.

2

The Government responds that Congress must generally

intend for agencies to resolve statutory ambiguities because agencies have subject matter expertise regarding the statutes they administer; because deferring to agencies purportedly promotes the uniform construction of federal law; and because resolving statutory ambiguities can involve policymaking best left to political actors, rather than courts. See Brief for Respondents in No. 22–1219, pp. 16–19. The dissent offers more of the same. See *post*, at 9–14. But none of these considerations justifies *Chevron*'s sweeping presumption of congressional intent.

Beginning with expertise, we recently noted that interpretive issues arising in connection with a regulatory scheme often "may fall more naturally into a judge's bailiwick" than an agency's. *Kisor*, 588 U. S., at 578 (opinion of the Court). We thus observed that "[w]hen the agency has no comparative expertise in resolving a regulatory ambiguity, Congress presumably would not grant it that authority." *Ibid.* *Chevron*'s broad rule of deference, though, demands that courts presume just the opposite. Under that rule, ambiguities of all stripes trigger deference. Indeed, the Government and, seemingly, the dissent continue to defend the proposition that *Chevron* applies even in cases having little to do with an agency's technical subject matter expertise. See Brief for Respondents in No. 22–1219, p. 17; *post*, at 10.

But even when an ambiguity happens to implicate a technical matter, it does not follow that Congress has taken the power to authoritatively interpret the statute from the courts and given it to the agency. Congress expects courts to handle technical statutory questions. "[M]any statutory cases" call upon "courts [to] interpret the mass of technical detail that is the ordinary diet of the law," *Egelhoff* v. *Egelhoff*, 532 U. S. 141, 161 (2001) (Breyer, J., dissenting), and courts did so without issue in agency cases before *Chevron*, see *post*, at 30 (GORSUCH, J., concurring). Courts, after all, do not decide such questions blindly. The parties and

amici in such cases are steeped in the subject matter, and reviewing courts have the benefit of their perspectives. In an agency case in particular, the court will go about its task with the agency's "body of experience and informed judgment," among other information, at its disposal. *Skidmore*, 323 U. S., at 140. And although an agency's interpretation of a statute "cannot bind a court," it may be especially informative "to the extent it rests on factual premises within [the agency's] expertise." *Bureau of Alcohol, Tobacco and Firearms* v. *FLRA*, 464 U. S. 89, 98, n. 8 (1983). Such expertise has always been one of the factors which may give an Executive Branch interpretation particular "power to persuade, if lacking power to control." *Skidmore*, 323 U. S., at 140; see, *e.g.*, *County of Maui* v. *Hawaii Wildlife Fund*, 590 U. S. 165, 180 (2020); *Moore*, 95 U. S., at 763.

For those reasons, delegating ultimate interpretive authority to agencies is simply not necessary to ensure that the resolution of statutory ambiguities is well informed by subject matter expertise. The better presumption is therefore that Congress expects courts to do their ordinary job of interpreting statutes, with due respect for the views of the Executive Branch. And to the extent that Congress and the Executive Branch may disagree with how the courts have performed that job in a particular case, they are of course always free to act by revising the statute.

Nor does a desire for the uniform construction of federal law justify *Chevron*. Given inconsistencies in how judges apply *Chevron*, see *infra*, at 30–33, it is unclear how much the doctrine as a whole (as opposed to its highly deferential second step) actually promotes such uniformity. In any event, there is little value in imposing a uniform interpretation of a statute if that interpretation is wrong. We see no reason to presume that Congress prefers uniformity for uniformity's sake over the correct interpretation of the laws it enacts.

The view that interpretation of ambiguous statutory provisions amounts to policymaking suited for political actors rather than courts is especially mistaken, for it rests on a profound misconception of the judicial role. It is reasonable to assume that Congress intends to leave policymaking to political actors. But resolution of statutory ambiguities involves legal interpretation. That task does not suddenly become policymaking just because a court has an "agency to fall back on." *Kisor*, 588 U. S., at 575 (opinion of the Court). Courts interpret statutes, no matter the context, based on the traditional tools of statutory construction, not individual policy preferences. Indeed, the Framers crafted the Constitution to ensure that federal judges could exercise judgment free from the influence of the political branches. See The Federalist, No. 78, at 522–525. They were to construe the law with "[c]lear heads . . . and honest hearts," not with an eye to policy preferences that had not made it into the statute. 1 Works of James Wilson 363 (J. Andrews ed. 1896).

That is not to say that Congress cannot or does not confer discretionary authority on agencies. Congress may do so, subject to constitutional limits, and it often has. But to stay out of discretionary policymaking left to the political branches, judges need only fulfill their obligations under the APA to independently identify and respect such delegations of authority, police the outer statutory boundaries of those delegations, and ensure that agencies exercise their discretion consistent with the APA. By forcing courts to instead pretend that ambiguities are necessarily delegations, *Chevron* does not prevent judges from making policy. It prevents them from judging.

3

In truth, *Chevron*'s justifying presumption is, as Members of this Court have often recognized, a fiction. See *Buffington* v. *McDonough*, 598 U. S. ___, ___ (2022) (GORSUCH,

J., dissenting from denial of certiorari) (slip op., at 11); *Cuozzo*, 579 U. S., at 286 (THOMAS, J., concurring); Scalia, 1989 Duke L. J., at 517; see also *post*, at 15 (opinion of KAGAN, J.). So we have spent the better part of four decades imposing one limitation on *Chevron* after another, pruning its presumption on the understanding that "where it is in doubt that Congress actually intended to delegate particular interpretive authority to an agency, *Chevron* is 'inapplicable.'" *United States* v. *Mead Corp.*, 533 U. S. 218, 230 (2001) (quoting *Christensen* v. *Harris County*, 529 U. S. 576, 597 (2000) (Breyer, J., dissenting)); see also *Adams Fruit Co.* v. *Barrett*, 494 U. S. 638, 649 (1990).

Consider the many refinements we have made in an effort to match *Chevron*'s presumption to reality. We have said that *Chevron* applies only "when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and that the agency interpretation claiming deference was promulgated in the exercise of that authority." *Mead*, 533 U. S., at 226–227. In practice, that threshold requirement—sometimes called *Chevron* "step zero"—largely limits *Chevron* to "the fruits of notice-and-comment rulemaking or formal adjudication." 533 U. S., at 230. But even when those processes are used, deference is still not warranted "where the regulation is 'procedurally defective'—that is, where the agency errs by failing to follow the correct procedures in issuing the regulation." *Encino Motorcars, LLC* v. *Navarro*, 579 U. S. 211, 220 (2016) (quoting *Mead*, 533 U. S., at 227).

Even where those procedural hurdles are cleared, substantive ones remain. Most notably, *Chevron* does not apply if the question at issue is one of "deep 'economic and political significance.'" *King* v. *Burwell*, 576 U. S. 473, 486 (2015). We have instead expected Congress to delegate such authority "expressly" if at all, *ibid.*, for "[e]xtraordinary grants of regulatory authority are rarely accomplished through 'modest words,' 'vague terms,' or 'subtle device[s],'"

West Virginia v. *EPA*, 597 U. S. 697, 723 (2022) (quoting *Whitman* v. *American Trucking Assns., Inc.*, 531 U. S. 457, 468 (2001); alteration in original). Nor have we applied *Chevron* to agency interpretations of judicial review provisions, see *Adams Fruit Co.*, 494 U. S., at 649–650, or to statutory schemes not administered by the agency seeking deference, see *Epic Systems Corp.* v. *Lewis*, 584 U. S. 497, 519–520 (2018). And we have sent mixed signals on whether *Chevron* applies when a statute has criminal applications. Compare *Abramski* v. *United States*, 573 U. S. 169, 191 (2014), with *Babbitt* v. *Sweet Home Chapter, Communities for Great Ore.*, 515 U. S. 687, 704, n. 18 (1995).

Confronted with this byzantine set of preconditions and exceptions, some courts have simply bypassed *Chevron*, saying it makes no difference for one reason or another.[7] And even when they do invoke *Chevron*, courts do not always heed the various steps and nuances of that evolving doctrine. In one of the cases before us today, for example, the First Circuit both skipped "step zero," see 62 F. 4th, at 628, and refused to "classify [its] conclusion as a product of *Chevron* step one or step two"—though it ultimately appears to have deferred under step two, *id.*, at 634.

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[7] See, *e.g.*, *Guedes* v. *Bureau of Alcohol, Tobacco, Firearms and Explosives*, 45 F. 4th 306, 313–314 (CADC 2022), abrogated by *Garland* v. *Cargill*, 602 U. S. ___ (2024); *County of Amador* v. *United States Dept. of Interior*, 872 F. 3d 1012, 1021–1022 (CA9 2017); *Estrada-Rodriguez* v. *Lynch*, 825 F. 3d 397, 403–404 (CA8 2016); *Nielsen* v. *AECOM Tech. Corp.*, 762 F. 3d 214, 220 (CA2 2014); *Alaska Stock, LLC* v. *Houghton Mifflin Harcourt Publishing Co.*, 747 F. 3d 673, 685, n. 52 (CA9 2014); *Jurado-Delgado* v. *Attorney Gen. of U. S.*, 498 Fed. Appx. 107, 117 (CA3 2009); see also D. Brookins, Confusion in the Circuit Courts: How the Circuit Courts Are Solving the *Mead*-Puzzle by Avoiding It Altogether, 85 Geo. Wash. L. Rev. 1484, 1496–1499 (2017) (documenting *Chevron* avoidance by the lower courts); A. Vermeule, Our Schmittian Administrative Law, 122 Harv. L. Rev. 1095, 1127–1129 (2009) (same); L. Bressman, How *Mead* Has Muddled Judicial Review of Agency Action, 58 Vand. L. Rev. 1443, 1464–1466 (2005) (same).

This Court, for its part, has not deferred to an agency interpretation under *Chevron* since 2016. See *Cuozzo*, 579 U. S., at 280 (most recent occasion). But *Chevron* remains on the books. So litigants must continue to wrestle with it, and lower courts—bound by even our crumbling precedents, see *Agostini* v. *Felton*, 521 U. S. 203, 238 (1997)—understandably continue to apply it.

The experience of the last 40 years has thus done little to rehabilitate *Chevron*. It has only made clear that *Chevron*'s fictional presumption of congressional intent was always unmoored from the APA's demand that courts exercise independent judgment in construing statutes administered by agencies. At best, our intricate *Chevron* doctrine has been nothing more than a distraction from the question that matters: Does the statute authorize the challenged agency action? And at worst, it has required courts to violate the APA by yielding to an agency the express responsibility, vested in "the reviewing *court*," to "decide all relevant questions of law" and "interpret . . . statutory provisions." §706 (emphasis added).

IV

The only question left is whether *stare decisis*, the doctrine governing judicial adherence to precedent, requires us to persist in the *Chevron* project. It does not. *Stare decisis* is not an "inexorable command," *Payne* v. *Tennessee*, 501 U. S. 808, 828 (1991), and the *stare decisis* considerations most relevant here—"the quality of [the precedent's] reasoning, the workability of the rule it established, . . . and reliance on the decision," *Knick* v. *Township of Scott*, 588 U. S. 180, 203 (2019) (quoting *Janus* v. *State, County, and Municipal Employees*, 585 U. S. 878, 917 (2018))—all weigh in favor of letting *Chevron* go.

Chevron has proved to be fundamentally misguided. Despite reshaping judicial review of agency action, neither it nor any case of ours applying it grappled with the APA—

the statute that lays out how such review works. Its flaws were nonetheless apparent from the start, prompting this Court to revise its foundations and continually limit its application. It has launched and sustained a cottage industry of scholars attempting to decipher its basis and meaning. And Members of this Court have long questioned its premises. See, *e.g.*, *Pereira* v. *Sessions*, 585 U. S. 198, 219–221 (2018) (Kennedy, J., concurring); *Michigan*, 576 U. S., at 760–764 (THOMAS, J., concurring); *Buffington*, 598 U. S. ___ (opinion of GORSUCH, J.); B. Kavanaugh, Fixing Statutory Interpretation, 129 Harv. L. Rev. 2118, 2150–2154 (2016). Even Justice Scalia, an early champion of *Chevron*, came to seriously doubt whether it could be reconciled with the APA. See *Perez*, 575 U. S., at 109–110 (opinion concurring in judgment). For its entire existence, *Chevron* has been a "rule in search of a justification," *Knick*, 588 U. S., at 204, if it was ever coherent enough to be called a rule at all.

Experience has also shown that *Chevron* is unworkable. The defining feature of its framework is the identification of statutory ambiguity, which requires deference at the doctrine's second step. But the concept of ambiguity has always evaded meaningful definition. As Justice Scalia put the dilemma just five years after *Chevron* was decided: "How clear is clear?" 1989 Duke L. J., at 521.

We are no closer to an answer to that question than we were four decades ago. "'[A]mbiguity' is a term that may have different meanings for different judges." *Exxon Mobil Corp.* v. *Allapattah Services, Inc.*, 545 U. S. 546, 572 (2005) (Stevens, J., dissenting). One judge might see ambiguity everywhere; another might never encounter it. Compare L. Silberman, Chevron—The Intersection of Law & Policy, 58 Geo. Wash. L. Rev. 821, 822 (1990), with R. Kethledge, Ambiguities and Agency Cases: Reflections After (Almost) Ten Years on the Bench, 70 Vand. L. Rev. En Banc 315, 323 (2017). A rule of law that is so wholly "in the eye of the

beholder," *Exxon Mobil Corp.*, 545 U. S., at 572 (Stevens, J., dissenting), invites different results in like cases and is therefore "arbitrary in practice," *Gulfstream Aerospace Corp.* v. *Mayacamas Corp.*, 485 U. S. 271, 283 (1988). Such an impressionistic and malleable concept "cannot stand as an every-day test for allocating" interpretive authority between courts and agencies. *Swift & Co.* v. *Wickham*, 382 U. S. 111, 125 (1965).

The dissent proves the point. It tells us that a court should reach *Chevron*'s second step when it finds, "at the end of its interpretive work," that "Congress has left an ambiguity or gap." *Post*, at 1–2. (The Government offers a similar test. See Brief for Respondents in No. 22–1219, pp. 7, 10, 14; Tr. of Oral Arg. 113–114, 116.) That is no guide at all. Once more, the basic nature and meaning of a statute does not change when an agency happens to be involved. Nor does it change just because the agency has happened to offer its interpretation through the sort of procedures necessary to obtain deference, or because the other preconditions for *Chevron* happen to be satisfied. The statute still has a best meaning, necessarily discernible by a court deploying its full interpretive toolkit. So for the dissent's test to have any meaning, it must think that in an agency case (unlike in any other), a court should give up on its "interpretive work" before it has identified that best meaning. But how does a court know when to do so? On that point, the dissent leaves a gap of its own. It protests only that some other interpretive tools—all with pedigrees more robust than *Chevron*'s, and all designed to help courts identify the meaning of a text rather than allow the Executive Branch to displace it—also apply to ambiguous texts. See *post*, at 27. That this is all the dissent can come up with, after four decades of judicial experience attempting to identify ambiguity under *Chevron*, reveals the futility of the

exercise.[8]

Because *Chevron* in its original, two-step form was so indeterminate and sweeping, we have instead been forced to clarify the doctrine again and again. Our attempts to do so have only added to *Chevron*'s unworkability, transforming the original two-step into a dizzying breakdance. See *Adams Fruit Co.*, 494 U. S., at 649–650; *Mead*, 533 U. S., at 226–227; *King*, 576 U. S., at 486; *Encino Motorcars*, 579 U. S., at 220; *Epic Systems*, 584 U. S., at 519–520; on and on. And the doctrine continues to spawn difficult threshold questions that promise to further complicate the inquiry should *Chevron* be retained. See, *e.g.*, *Cargill* v. *Garland*, 57 F. 4th 447, 465–468 (CA5 2023) (plurality opinion) (May the Government waive reliance on *Chevron*? Does *Chevron* apply to agency interpretations of statutes imposing criminal penalties? Does *Chevron* displace the rule of lenity?), aff'd, 602 U. S. ___ (2024).

Four decades after its inception, *Chevron* has thus become an impediment, rather than an aid, to accomplishing the basic judicial task of "say[ing] what the law is." *Marbury*, 1 Cranch, at 177. And its continuing import is far from clear. Courts have often declined to engage with the doctrine, saying it makes no difference. See n. 7, *supra*. And as noted, we have avoided deferring under *Chevron* since 2016. That trend is nothing new; for decades, we have often declined to invoke *Chevron* even in those cases where it might appear to be applicable. See W. Eskridge & L. Baer, The Continuum of Deference: Supreme Court Treatment of Agency Statutory Interpretations From *Chevron* to *Hamdan*, 96 Geo. L. J. 1083, 1125 (2008). At this point, all

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[8] Citing an empirical study, the dissent adds that *Chevron* "fosters *agreement* among judges." *Post*, at 28. It is hardly surprising that a study might find as much; *Chevron*'s second step is supposed to be hospitable to agency interpretations. So when judges get there, they tend to agree that the agency wins. That proves nothing about the supposed ease or predictability of identifying ambiguity in the first place.

that remains of *Chevron* is a decaying husk with bold pretensions.

Nor has *Chevron* been the sort of "'stable background' rule" that fosters meaningful reliance. *Post*, at 8, n. 1 (opinion of KAGAN, J.) (quoting *Morrison* v. *National Australia Bank Ltd.*, 561 U. S. 247, 261 (2010)). Given our constant tinkering with and eventual turn away from *Chevron*, and its inconsistent application by the lower courts, it instead is hard to see how anyone—Congress included—could reasonably expect a court to rely on *Chevron* in any particular case. And even if it were possible to predict accurately when courts will apply *Chevron*, the doctrine "does not provide 'a clear or easily applicable standard, so arguments for reliance based on its clarity are misplaced.'" *Janus*, 585 U. S., at 927 (quoting *South Dakota* v. *Wayfair, Inc.*, 585 U. S. 162, 186 (2018)). To plan on *Chevron* yielding a particular result is to gamble not only that the doctrine will be invoked, but also that it will produce readily foreseeable outcomes and the stability that comes with them. History has proved neither bet to be a winning proposition.

Rather than safeguarding reliance interests, *Chevron* affirmatively destroys them. Under *Chevron*, a statutory ambiguity, no matter why it is there, becomes a license authorizing an agency to change positions as much as it likes, with "[u]nexplained inconsistency" being "at most . . . a reason for holding an interpretation to be . . . arbitrary and capricious." *Brand X*, 545 U. S., at 981. But statutory ambiguity, as we have explained, is not a reliable indicator of actual delegation of discretionary authority to agencies. *Chevron* thus allows agencies to change course even when Congress has given them no power to do so. By its sheer breadth, *Chevron* fosters unwarranted instability in the law, leaving those attempting to plan around agency action in an eternal fog of uncertainty.

Chevron accordingly has undermined the very "rule of law" values that *stare decisis* exists to secure. *Michigan* v.

Bay Mills Indian Community, 572 U. S. 782, 798 (2014). And it cannot be constrained by admonishing courts to be extra careful, or by tacking on a new batch of conditions. We would need to once again "revis[e] its theoretical basis . . . in order to cure its practical deficiencies." *Montejo* v. *Louisiana*, 556 U. S. 778, 792 (2009). *Stare decisis* does not require us to do so, especially because any refinements we might make would only point courts back to their duties under the APA to "decide all relevant questions of law" and "interpret . . . statutory provisions." §706. Nor is there any reason to wait helplessly for Congress to correct our mistake. The Court has jettisoned many precedents that Congress likewise could have legislatively overruled. See, *e.g.*, *Patterson* v. *McLean Credit Union*, 485 U. S. 617, 618 (1988) (*per curiam*) (collecting cases). And part of "judicial humility," *post*, at 3, 25 (opinion of KAGAN, J.,), is admitting and in certain cases correcting our own mistakes, especially when those mistakes are serious, see *post*, at 8–9 (opinion of GORSUCH, J.).

This is one of those cases. *Chevron* was a judicial invention that required judges to disregard their statutory duties. And the only way to "ensure that the law will not merely change erratically, but will develop in a principled and intelligible fashion," *Vasquez* v. *Hillery*, 474 U. S. 254, 265 (1986), is for us to leave *Chevron* behind.

By doing so, however, we do not call into question prior cases that relied on the *Chevron* framework. The holdings of those cases that specific agency actions are lawful—including the Clean Air Act holding of *Chevron* itself—are still subject to statutory *stare decisis* despite our change in interpretive methodology. See *CBOCS West, Inc.* v. *Humphries*, 553 U. S. 442, 457 (2008). Mere reliance on *Chevron* cannot constitute a "'special justification'" for overruling such a holding, because to say a precedent relied on *Chevron* is, at best, "just an argument that the precedent was wrongly decided." *Halliburton Co.* v. *Erica P. John Fund,*

Inc., 573 U. S. 258, 266 (2014) (quoting *Dickerson* v. *United States*, 530 U. S. 428, 443 (2000)). That is not enough to justify overruling a statutory precedent.

* * *

The dissent ends by quoting *Chevron*: "'Judges are not experts in the field.'" *Post*, at 31 (quoting 467 U. S., at 865). That depends, of course, on what the "field" is. If it is legal interpretation, that has been, "emphatically," "the province and duty of the judicial department" for at least 221 years. *Marbury*, 1 Cranch, at 177. The rest of the dissent's selected epigraph is that judges "'are not part of either political branch.'" *Post*, at 31 (quoting *Chevron*, 467 U. S., at 865). Indeed. Judges have always been expected to apply their "judgment" *independent* of the political branches when interpreting the laws those branches enact. The Federalist No. 78, at 523. And one of those laws, the APA, bars judges from disregarding that responsibility just because an Executive Branch agency views a statute differently.

Chevron is overruled. Courts must exercise their independent judgment in deciding whether an agency has acted within its statutory authority, as the APA requires. Careful attention to the judgment of the Executive Branch may help inform that inquiry. And when a particular statute delegates authority to an agency consistent with constitutional limits, courts must respect the delegation, while ensuring that the agency acts within it. But courts need not and under the APA may not defer to an agency interpretation of the law simply because a statute is ambiguous.

Because the D. C. and First Circuits relied on *Chevron* in deciding whether to uphold the Rule, their judgments are vacated, and the cases are remanded for further proceedings consistent with this opinion.

It is so ordered.

SUPREME COURT OF THE UNITED STATES

Nos. 22–451 and 22–1219

LOPER BRIGHT ENTERPRISES, ET AL.,
PETITIONERS
22–451 *v.*
GINA RAIMONDO, SECRETARY OF
COMMERCE, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

RELENTLESS, INC., ET AL., PETITIONERS
22–1219 *v.*
DEPARTMENT OF COMMERCE, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

[June 28, 2024]

JUSTICE THOMAS, concurring.

I join the Court's opinion in full because it correctly concludes that *Chevron U. S. A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U. S. 837 (1984), must finally be overruled. Under *Chevron*, a judge was required to adopt an agency's interpretation of an ambiguous statute, so long as the agency had a "permissible construction of the statute." See *id.*, at 843. As the Court explains, that deference does not comport with the Administrative Procedure Act, which requires judges to decide "all relevant questions of law" and "interpret constitutional and statutory provisions" when reviewing an agency action. 5 U. S. C. §706; see also *ante,* at 18–23; *Baldwin* v. *United States*, 589 U. S. ___, ___–___ (2020) (THOMAS, J., dissenting from denial of certiorari) (slip op., at 4–5).

I write separately to underscore a more fundamental problem: *Chevron* deference also violates our Constitution's separation of powers, as I have previously explained at length. See *Baldwin*, 589 U. S., at ___–___ (dissenting opinion) (slip op., at 2–4); *Michigan* v. *EPA*, 576 U. S. 743, 761–763 (2015) (concurring opinion); see also *Perez* v. *Mortgage Bankers Assn.*, 575 U. S. 92, 115–118 (2015) (opinion concurring in judgment). And, I agree with JUSTICE GORSUCH that we should not overlook *Chevron*'s constitutional defects in overruling it.* *Post*, at 15–20 (concurring opinion). To provide "practical and real protections for individual liberty," the Framers drafted a Constitution that divides the legislative, executive, and judicial powers between three branches of Government. *Perez*, 575 U. S., at 118 (opinion of THOMAS, J.). *Chevron* deference compromises this separation of powers in two ways. It curbs the judicial power afforded to courts, and simultaneously expands agencies' executive power beyond constitutional limits.

Chevron compels judges to abdicate their Article III "judicial Power." §1. "[T]he judicial power, as originally understood, requires a court to exercise its independent judgment in interpreting and expounding upon the laws." *Perez*, 575 U. S., at 119 (opinion of THOMAS, J.); accord, *post*, at 17–18 (opinion of GORSUCH, J.). The Framers understood that "legal texts . . . often contain ambiguities," and that the judicial power included "the power to resolve these ambiguities over time." *Perez*, 575 U. S., at 119 (opinion of THOMAS, J.); accord, *ante,* at 7–9. But, under *Chevron*, a judge must accept an agency's interpretation of an ambiguous law, even if he thinks another interpretation is correct. *Ante*, at 19. *Chevron* deference thus prevents judges from

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*There is much to be commended in JUSTICE GORSUCH's careful consideration from first principles of the weight we should afford to our precedent. I agree with the lion's share of his concurrence. See generally *Gamble* v. *United States*, 587 U. S. 678, 710 (2019) (THOMAS, J., concurring).

exercising their independent judgment to resolve ambiguities. *Baldwin*, 589 U. S., at ___ (opinion of THOMAS, J.) (slip op., at 3); see also *Michigan*, 576 U. S., at 761 (opinion of THOMAS, J.); see also *Perez*, 575 U. S., at 123 (opinion of THOMAS, J.). By tying a judge's hands, *Chevron* prevents the Judiciary from serving as a constitutional check on the Executive. It allows "the Executive . . . to dictate the outcome of cases through erroneous interpretations." *Baldwin*, 589 U. S., at ___ (opinion of THOMAS, J.) (slip op., at 4); *Michigan*, 576 U. S., at 763, n. 1 (opinion of THOMAS, J.); see also *Perez*, 575 U. S., at 124 (opinion of THOMAS, J.). Because the judicial power requires judges to exercise their independent judgment, the deference that *Chevron* requires contravenes Article III's mandate.

Chevron deference also permits the Executive Branch to exercise powers not given to it. "When the Government is called upon to perform a function that requires an exercise of legislative, executive, or judicial power, only the vested recipient of that power can perform it." *Department of Transportation* v. *Association of American Railroads*, 575 U. S. 43, 68 (2015) (THOMAS, J., concurring in judgment). Because the Constitution gives the Executive Branch only "[t]he executive Power," executive agencies may constitutionally exercise only that power. Art. II, §1, cl. 1. But, *Chevron* gives agencies license to exercise judicial power. By allowing agencies to definitively interpret laws so long as they are ambiguous, *Chevron* "transfer[s]" the Judiciary's "interpretive judgment to the agency." *Perez*, 575 U. S., at 124 (opinion of THOMAS, J.); see also *Baldwin*, 589 U. S., at ___ (opinion of THOMAS, J.) (slip op., at 4); *Michigan*, 576 U. S., at 761–762 (opinion of THOMAS, J.); *post*, at 18 (GORSUCH, J., concurring).

Chevron deference "cannot be salvaged" by recasting it as deference to an agency's "formulation of policy." *Baldwin*, 589 U. S., at ___ (opinion of THOMAS, J.) (internal quotation marks omitted) (slip op., at 3). If that were true, *Chevron*

would mean that "agencies are unconstitutionally exercising 'legislative Powers' vested in Congress." *Baldwin*, 589 U. S., at ___ (opinion of THOMAS, J.) (slip op., at 3) (quoting Art. I, §1). By "giv[ing] the force of law to agency pronouncements on matters of private conduct as to which Congress did not actually have an intent," *Chevron* "permit[s] a body other than Congress to perform a function that requires an exercise of legislative power." *Michigan*, 576 U. S., at 762 (opinion of THOMAS, J.) (internal quotation marks omitted). No matter the gloss put on it, *Chevron* expands agencies' power beyond the bounds of Article II by permitting them to exercise powers reserved to another branch of Government.

Chevron deference was "not a harmless transfer of power." *Baldwin*, 589 U. S., at ___ (opinion of THOMAS, J.) (slip op., at 3). "The Constitution carefully imposes structural constraints on all three branches, and the exercise of power free of those accompanying restraints subverts the design of the Constitution's ratifiers." *Ibid.* In particular, the Founders envisioned that "the courts [would] check the Executive by applying the correct interpretation of the law." *Id.*, at ___ (slip op., at 4). *Chevron* was thus a fundamental disruption of our separation of powers. It improperly strips courts of judicial power by simultaneously increasing the power of executive agencies. By overruling *Chevron*, we restore this aspect of our separation of powers. To safeguard individual liberty, "[s]tructure is everything." A. Scalia, Foreword: The Importance of Structure in Constitutional Interpretation, 83 Notre Dame L. Rev. 1417, 1418 (2008). Although the Court finally ends our 40-year misadventure with *Chevron* deference, its more profound problems should not be overlooked. Regardless of what a statute says, the type of deference required by *Chevron* violates the Constitution.

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[June 28, 2024]

JUSTICE GORSUCH, concurring.

In disputes between individuals and the government about the meaning of a federal law, federal courts have traditionally sought to offer independent judgments about "what the law is" without favor to either side. *Marbury* v. *Madison*, 1 Cranch 137, 177 (1803). Beginning in the mid-1980s, however, this Court experimented with a radically different approach. Applying *Chevron* deference, judges began deferring to the views of executive agency officials about the meaning of federal statutes. See *Chevron U. S. A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U. S. 837 (1984). With time, the error of this approach became widely appreciated. So much so that this Court has refused to apply *Chevron* deference since 2016. Today, the Court places a tombstone on *Chevron* no one can miss. In doing

so, the Court returns judges to interpretive rules that have guided federal courts since the Nation's founding. I write separately to address why the proper application of the doctrine of *stare decisis* supports that course.

I

A

Today, the phrase "common law judge" may call to mind a judicial titan of the past who brilliantly devised new legal rules on his own. The phrase "*stare decisis*" might conjure up a sense that judges who come later in time are strictly bound to follow the work of their predecessors. But neither of those intuitions fairly describes the traditional common-law understanding of the judge's role or the doctrine of *stare decisis*.

At common law, a judge's charge to decide cases was not usually understood as a license to make new law. For much of England's early history, different rulers and different legal systems prevailed in different regions. As England consolidated into a single kingdom governed by a single legal system, the judge's task was to examine those pre-existing legal traditions and apply in the disputes that came to him those legal rules that were "common to the whole land and to all Englishmen." F. Maitland, Equity, Also the Forms of Action at Common Law 2 (1929). That was "common law" judging.

This view of the judge's role had consequences for the authority due judicial decisions. Because a judge's job was to find and apply the law, not make it, the "opinion of the judge" and "the law" were not considered "one and the same thing." 1 W. Blackstone, Commentaries on the Laws of England 71 (1765) (Blackstone) (emphasis deleted). A judge's decision might bind the parties to the case at hand. M. Hale, The History and Analysis of the Common Law of England 68 (1713) (Hale). But none of that meant the judge had the power to "make a Law properly so called" for society

at large, "for that only the King and Parliament can do." *Ibid.*

Other consequences followed for the role precedent played in future judicial proceedings. Because past decisions represented something "less than a Law," they did not bind future judges. *Ibid.* At the same time, as Matthew Hale put it, a future judge could give a past decision "Weight" as "Evidence" of the law. *Ibid.* Expressing the same idea, William Blackstone conceived of judicial precedents as "evidence" of "the common law." 1 Blackstone 69, 71. And much like other forms of evidence, precedents at common law were thought to vary in the weight due them. Some past decisions might supply future courts with considerable guidance. But others might be entitled to lesser weight, not least because judges are no less prone to error than anyone else and they may sometimes "mistake" what the law demands. *Id.*, at 71 (emphasis deleted). In cases like that, both men thought, a future judge should not rotely repeat a past mistake but instead "vindicate" the law "from misrepresentation." *Id.*, at 70.

When examining past decisions as evidence of the law, common law judges did not, broadly speaking, afford overwhelming weight to any "single precedent." J. Baker, An Introduction to English Legal History 209–210 (5th ed. 2019). Instead, a prior decision's persuasive force depended in large measure on its "Consonancy and Congruity with Resolutions and Decisions of former Times." Hale 68. An individual decision might reflect the views of one court at one moment in time, but a consistent line of decisions representing the wisdom of many minds across many generations was generally considered stronger evidence of the law's meaning. *Ibid.*

With this conception of precedent in mind, Lord Mansfield cautioned against elevating "particular cases" above the "general principles" that "run through the cases, and govern the decision of them." *Rust* v. *Cooper*, 2 Cowp. 629,

632, 98 Eng. Rep. 1277, 1279 (K. B. 1777). By discarding aberrational rulings and pursuing instead the mainstream of past decisions, he observed, the common law tended over time to "wor[k] itself pure." *Omychund* v. *Barker*, 1 Atk. 22, 33, 26 Eng. Rep. 15, 23 (Ch. 1744) (emphasis deleted). Reflecting similar thinking, Edmund Burke offered five principles for the evaluation of past judicial decisions: "They ought to be shewn; first, to be numerous and not scattered here and there;—secondly, concurrent and not contradictory and mutually destructive;—thirdly, to be made in good and constitutional times;—fourthly, not to be made to serve an occasion;—and fifthly, to be agreeable to the general tenor of legal principles." Speech of Dec. 23, 1790, in 3 The Speeches of the Right Honourable Edmund Burke 513 (1816).

Not only did different decisions carry different weight, so did different language within a decision. An opinion's holding and the reasoning essential to it (the *ratio decidendi*) merited careful attention. Dicta, stray remarks, and digressions warranted less weight. See N. Duxbury, The Intricacies of Dicta and Dissent 19–24 (2021) (Duxbury). These were no more than "the vapours and fumes of law." F. Bacon, The Lord Keeper's Speech in the Exchequer (1617), in 2 The Works of Francis Bacon 478 (B. Montagu ed. 1887) (Bacon).

That is not to say those "vapours" were worthless. Often dicta might provide the parties to a particular dispute a "fuller understanding of the court's decisional path or related areas of concern." B. Garner et al., The Law of Judicial Precedent 65 (2016) (Precedent). Dicta might also provide future courts with a source of "thoughtful advice." *Ibid.* But future courts had to be careful not to treat every "hasty expression . . . as a serious and deliberate opinion." *Steel* v. *Houghton*, 1 Bl. H. 51, 53, 126 Eng. Rep. 32, 33 (C. P. 1788). To do so would work an "injustice to [the] memory" of their predecessors who could not expect judicial

remarks issued in one context to apply perfectly in others, perhaps especially ones they could not foresee. *Ibid.* Also, the limits of the adversarial process, a distinctive feature of English law, had to be borne in mind. When a single judge or a small panel reached a decision in a case, they did so based on the factual record and legal arguments the parties at hand have chosen to develop. Attuned to those constraints, future judges had to proceed with an open mind to the possibility that different facts and different legal arguments might dictate different outcomes in later disputes. See Duxbury 19–24.

B

Necessarily, this represents just a quick sketch of traditional common-law understandings of the judge's role and the place of precedent in it. It focuses, too, on the horizontal, not vertical, force of judicial precedents. But there are good reasons to think that the common law's understandings of judges and precedent outlined above crossed the Atlantic and informed the nature of the "judicial Power" the Constitution vests in federal courts. Art. III, §1.

Not only was the Constitution adopted against the backdrop of these understandings and, in light of that alone, they may provide evidence of what the framers meant when they spoke of the "judicial Power." Many other, more specific provisions in the Constitution reflect much the same distinction between lawmaking and lawfinding functions the common law did. The Constitution provides that its terms may be amended only through certain prescribed democratic processes. Art. V. It vests the power to enact federal legislation exclusively in the people's elected representatives in Congress. Art. I, §1. Meanwhile, the Constitution describes the judicial power as the power to resolve cases and controversies. Art. III, §2, cl. 1. As well, it delegates that authority to life-tenured judges, see §1, an assignment that would have made little sense if judges could

usurp lawmaking powers vested in periodically elected representatives. But one that makes perfect sense if what is sought is a neutral party "to interpret and apply" the law without fear or favor in a dispute between others. 2 The Works of James Wilson 161 (J. Andrews ed. 1896) (Wilson); see *Osborn* v. *Bank of United States*, 9 Wheat. 738, 866 (1824).

The constrained view of the judicial power that runs through our Constitution carries with it familiar implications, ones the framers readily acknowledged. James Madison, for example, proclaimed that it would be a "fallacy" to suggest that judges or their precedents could "repeal or alter" the Constitution or the laws of the United States. Letter to N. Trist (Dec. 1831), in 9 The Writings of James Madison 477 (G. Hunt ed. 1910). A court's opinion, James Wilson added, may be thought of as "effective la[w]" "[a]s to the parties." Wilson 160–161. But as in England, Wilson said, a prior judicial decision could serve in a future dispute only as "evidence" of the law's proper construction. *Id.*, at 160; accord, 1 J. Kent, Commentaries on American Law 442–443 (1826).

The framers also recognized that the judicial power described in our Constitution implies, as the judicial power did in England, a power (and duty) of discrimination when it comes to assessing the "evidence" embodied in past decisions. So, for example, Madison observed that judicial rulings "*repeatedly confirmed*" may supply better evidence of the law's meaning than isolated or aberrant ones. Letter to C. Ingersoll (June 1831), in 4 Letters and Other Writings of James Madison 184 (1867) (emphasis added). Extending the thought, Thomas Jefferson believed it would often take "numerous decisions" for the meaning of new statutes to become truly "settled." Letter to S. Jones (July 1809), in 12 The Writings of Thomas Jefferson 299 (A. Bergh ed. 1907).

From the start, too, American courts recognized that not everything found in a prior decision was entitled to equal

weight. As Chief Justice Marshall warned, "It is a maxim not to be disregarded, that general expressions, in every opinion, are to be taken in connection with the case in which those expressions are used." *Cohens* v. *Virginia*, 6 Wheat. 264, 399 (1821). To the extent a past court offered views "beyond the case," those expressions "may be respected" in a later case "but ought not to control the judgment." *Ibid.* One "obvious" reason for this, Marshall continued, had to do with the limits of the adversarial process we inherited from England: Only "[t]he question actually before the Court is investigated with care, and considered in its full extent. Other principles which may serve to illustrate it, are considered in their relation to the case decided, but their possible bearing on all other cases is seldom completely investigated." *Id.*, at 399–400.

Abraham Lincoln championed these traditional understandings in his debates with Stephen Douglas. Douglas took the view that a single decision of this Court—no matter how flawed—could definitively resolve a contested issue for everyone and all time. Those who thought otherwise, he said, "aim[ed] a deadly blow to our whole Republican system of government." Speech at Springfield, Ill. (June 26, 1857), in 2 The Collected Works of Abraham Lincoln 401 (R. Basler ed. 1953) (Lincoln Speech). But Lincoln knew better. While accepting that judicial decisions "absolutely determine" the rights of the parties to a court's judgment, he refused to accept that any single judicial decision could "fully settl[e]" an issue, particularly when that decision departs from the Constitution. *Id.*, at 400–401. In cases such as these, Lincoln explained, "it is not resistance, it is not factious, it is not even disrespectful, to treat [the decision] as not having yet quite established a settled doctrine for the country." *Id.*, at 401.

After the Civil War, the Court echoed some of these same points. It stressed that every statement in a judicial opin-

ion "must be taken in connection with its immediate context," *In re Ayers*, 123 U. S. 443, 488 (1887), and stray "remarks" must not be elevated above the written law, see *The Belfast*, 7 Wall. 624, 641 (1869); see also, *e.g.*, *Trebilcock* v. *Wilson*, 12 Wall. 687, 692–693 (1872); *Mason* v. *Eldred*, 6 Wall. 231, 236–238 (1868). During Chief Justice Chase's tenure, it seems a Justice writing the Court's majority opinion would generally work alone and present his work orally and in summary form to his colleagues at conference, which meant that other Justices often did not even review the opinion prior to publication. 6 C. Fairman, History of the Supreme Court of the United States 69–70 (1971). The Court could proceed in this way because it understood that a single judicial opinion may resolve a "case or controversy," and in so doing it may make "effective law" for the parties, but it does not legislate for the whole of the country and is not to be confused with laws that do.

C

From all this, I see at least three lessons about the doctrine of *stare decisis* relevant to the decision before us today. Each concerns a form of judicial humility.

First, a past decision may bind the parties to a dispute, but it provides this Court no authority in future cases to depart from what the Constitution or laws of the United States ordain. Instead, the Constitution promises, the American people are sovereign and they alone may, through democratically responsive processes, amend our foundational charter or revise federal legislation. Unelected judges enjoy no such power. Part I–B, *supra*.

Recognizing as much, this Court has often said that *stare decisis* is not an "'inexorable command.'" *State Oil Co.* v. *Khan*, 522 U. S. 3, 20 (1997). And from time to time it has found it necessary to correct its past mistakes. When it comes to correcting errors of constitutional interpretation, the Court has stressed the importance of doing so, for they

can be corrected otherwise only through the amendment process. See, *e.g.*, *Franchise Tax Bd. of Cal.* v. *Hyatt*, 587 U. S. 230, 248 (2019). When it comes to fixing errors of statutory interpretation, the Court has proceeded perhaps more circumspectly. But in that field, too, it has overruled even longstanding but "flawed" decisions. See, *e.g.*, *Leegin Creative Leather Products, Inc.* v. *PSKS, Inc.*, 551 U. S. 877, 904, 907 (2007).

Recent history illustrates all this. During the tenures of Chief Justices Warren and Burger, it seems this Court overruled an average of around three cases per Term, including roughly 50 statutory precedents between the 1960s and 1980s alone. See W. Eskridge, Overruling Statutory Precedents, 76 Geo. L. J. 1361, 1427–1434 (1988) (collecting cases). Many of these decisions came in settings no less consequential than today's. In recent years, we have not approached the pace set by our predecessors, overruling an average of just one or two prior decisions each Term.[1] But the point remains: Judicial decisions inconsistent with the written law do not inexorably control.

Second, another lesson tempers the first. While judicial decisions may not supersede or revise the Constitution or federal statutory law, they merit our "respect as embodying the considered views of those who have come before." *Ramos* v. *Louisiana*, 590 U. S. 83, 105 (2020). As a matter of professional responsibility, a judge must not only avoid confusing his writings with the law. When a case comes before him, he must also weigh his view of what the law demands against the thoughtful views of his predecessors. After all, "[p]recedent is a way of accumulating and passing down the learning of past generations, a font of established wisdom

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[1] For relevant databases of decisions, see Congressional Research Service, Table of Supreme Court Decisions Overruled by Subsequent Decisions, Constitution Annotated, https://constitution.congress.gov/resources/decisions-overruled/; see also H. Spaeth et al., 2023 Supreme Court Database, http://supremecourtdatabase.org.

richer than what can be found in any single judge or panel of judges." Precedent 9.

Doubtless, past judicial decisions may, as they always have, command "greater or less authority as precedents, according to circumstances." Lincoln Speech 401. But, like English judges before us, we have long turned to familiar considerations to guide our assessment of the weight due a past decision. So, for example, as this Court has put it, the weight due a precedent may depend on the quality of its reasoning, its consistency with related decisions, its workability, and reliance interests that have formed around it. See *Ramos*, 590 U. S., at 106. The first factor recognizes that the primary power of any precedent lies in its power to persuade—and poorly reasoned decisions may not provide reliable evidence of the law's meaning. The second factor reflects the fact that a precedent is more likely to be correct and worthy of respect when it reflects the time-tested wisdom of generations than when it sits "unmoored" from surrounding law. *Ibid.* The remaining factors, like workability and reliance, do not often supply reason enough on their own to abide a flawed decision, for almost any past decision is likely to benefit some group eager to keep things as they are and content with how things work. See, *e.g.*, *id.*, at 108. But these factors can sometimes serve functions similar to the others, by pointing to clues that may suggest a past decision is right in ways not immediately obvious to the individual judge.

When asking whether to follow or depart from a precedent, some judges deploy adverbs. They speak of whether or not a precedent qualifies as "demonstrably erroneous," *Gamble* v. *United States*, 587 U. S. 678, 711 (2019) (THOMAS, J., concurring), or "egregiously wrong," *Ramos*, 590 U. S., at 121 (KAVANAUGH, J., concurring in part). But the emphasis the adverb imparts is not meant for dramatic effect. It seeks to serve instead as a reminder of a more substantive lesson. The lesson that, in assessing the weight

due a past decision, a judge is not to be guided by his own impression alone, but must self-consciously test his views against those who have come before, open to the possibility that a precedent might be correct in ways not initially apparent to him.

Third, it would be a mistake to read judicial opinions like statutes. Adopted through a robust and democratic process, statutes often apply in all their particulars to all persons. By contrast, when judges reach a decision in our adversarial system, they render a judgment based only on the factual record and legal arguments the parties at hand have chosen to develop. A later court assessing a past decision must therefore appreciate the possibility that different facts and different legal arguments may dictate a different outcome. They must appreciate, too, that, like anyone else, judges are "innately digressive," and their opinions may sometimes offer stray asides about a wider topic that may sound nearly like legislative commands. Duxbury 4. Often, enterprising counsel seek to exploit such statements to maximum effect. See *id*., at 25. But while these digressions may sometimes contain valuable counsel, they remain "vapours and fumes of law," Bacon 478, and cannot "control the judgment in a subsequent suit," *Cohens*, 6 Wheat., at 399.

These principles, too, have long guided this Court and others. As Judge Easterbrook has put it, an "opinion is not a comprehensive code; it is just an explanation for the Court's disposition. Judicial opinions must not be confused with statutes, and general expressions must be read in light of the subject under consideration." *United States* v. *Skoien*, 614 F. 3d 638, 640 (CA7 2010) (en banc); see also *Reiter* v. *Sonotone Corp.*, 442 U. S. 330, 341 (1979) (stressing that an opinion is not "a statute," and its language should not "be parsed" as if it were); *Nevada* v. *Hicks*, 533 U. S. 353, 372 (2001) (same). If *stare decisis* counsels respect for the thinking of those who have come before, it also counsels against doing an "injustice to [their] memory" by

overreliance on their every word. *Steel*, 1 Bl. H., at 53, 126 Eng. Rep., at 33. As judges, "[w]e neither expect nor hope that our successors will comb" through our opinions, searching for delphic answers to matters we never fully explored. *Brown* v. *Davenport*, 596 U. S. 118, 141 (2022). To proceed otherwise risks "turn[ing] *stare decisis* from a tool of judicial humility into one of judicial hubris." *Ibid.*

II

Turning now directly to the question what *stare decisis* effect *Chevron* deference warrants, each of these lessons seem to me to weigh firmly in favor of the course the Court charts today: Lesson 1, because *Chevron* deference contravenes the law Congress prescribed in the Administrative Procedure Act. Lesson 2, because *Chevron* deference runs against mainstream currents in our law regarding the separation of powers, due process, and centuries-old interpretive rules that fortify those constitutional commitments. And Lesson 3, because to hold otherwise would effectively require us to endow stray statements in *Chevron* with the authority of statutory language, all while ignoring more considered language in that same decision and the teachings of experience.

A

Start with Lesson 1. The Administrative Procedure Act of 1946 (APA) directs a "reviewing court" to "decide all relevant questions of law" and "interpret" relevant "constitutional and statutory provisions." 5 U. S. C. §706. When applying *Chevron* deference, reviewing courts do not interpret all relevant statutory provisions and decide all relevant questions of law. Instead, judges abdicate a large measure of that responsibility in favor of agency officials. Their interpretations of "ambiguous" laws control even when those interpretations are at odds with the fairest reading of the law an independent "reviewing court" can muster. Agency

officials, too, may change their minds about the law's meaning at any time, even when Congress has not amended the relevant statutory language in any way. *National Cable & Telecommunications Assn.* v. *Brand X Internet Services*, 545 U. S. 967, 982–983 (2005). And those officials may even disagree with and effectively overrule not only their own past interpretations of a law but a court's past interpretation as well. *Ibid.* None of that is consistent with the APA's clear mandate.

The hard fact is *Chevron* "did not even bother to cite" the APA, let alone seek to apply its terms. *United States* v. *Mead Corp.*, 533 U. S. 218, 241 (2001) (Scalia, J., dissenting). Instead, as even its most ardent defenders have conceded, *Chevron* deference rests upon a "*fictionalized* statement of legislative desire," namely, a judicial supposition that Congress implicitly wishes judges to defer to executive agencies' interpretations of the law even when it has said nothing of the kind. D. Barron & E. Kagan, Chevron's Nondelegation Doctrine, 2001 S. Ct. Rev. 201, 212 (Kagan) (emphasis added). As proponents see it, that fiction represents a "policy judgmen[t] about what . . . make[s] for good government." *Ibid.*[2] But in our democracy unelected judges possess no authority to elevate their own fictions over the laws adopted by the Nation's elected representatives. Some might think the legal directive Congress provided in the APA unwise; some might think a different arrangement preferable. See, *e.g.*, *post*, at 9–11 (KAGAN, J., dissenting). But it is Congress's view of "good government," not ours, that controls.

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[2] See also A. Scalia, Judicial Deference to Administrative Interpretations of Law, 1989 Duke L. J. 511, 516–517 (1989) (describing *Chevron*'s theory that Congress "delegat[ed]" interpretive authority to agencies as "fictional"); S. Breyer, Judicial Review of Questions of Law and Policy, 38 Admin. L. Rev. 363, 370 (1986) (describing the notion that there exists a "'legislative intent to delegate the law-interpreting function' as a kind of legal fiction").

Much more could be said about *Chevron*'s inconsistency with the APA. But I have said it in the past. See *Buffington* v. *McDonough*, 598 U. S. ___, ___–___ (2022) (opinion dissenting from denial of certiorari) (slip op., at 5–6); *Gutierrez-Brizuela* v. *Lynch*, 834 F. 3d 1142, 1151–1153 (CA10 2016) (concurring opinion). And the Court makes many of the same points at length today. See *ante*, at 18–22. For present purposes, the short of it is that continuing to abide *Chevron* deference would require us to transgress the first lesson of *stare decisis*—the humility required of judges to recognize that our decisions must yield to the laws adopted by the people's elected representatives.[3]

B

Lesson 2 cannot rescue *Chevron* deference. If *stare decisis* calls for judicial humility in the face of the written law, it also cautions us to test our present conclusions carefully against the work of our predecessors. At the same time and as we have seen, this second form of humility counsels us to remember that precedents that have won the endorsement of judges across many generations, demonstrated coherence with our broader law, and weathered the tests of time and experience are entitled to greater consideration than those that have not. See Part I, *supra*. Viewed by each of these lights, the case for *Chevron* deference only grows weaker still.

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[3] The dissent suggests that we need not take the APA's directions quite so seriously because the "finest administrative law scholars" from Harvard claim to see in them some wiggle room. *Post*, at 18 (opinion of KAGAN, J.). But nothing in the APA commands deference to the views of professors any more than it does the government. Nor is the dissent's list of Harvard's finest administrative law scholars entirely complete. See S. Breyer et al., Administrative Law and Regulatory Policy 288 (7th ed. 2011) (acknowledging that *Chevron* deference "seems in conflict with . . . the apparently contrary language of 706"); Kagan 212 (likewise acknowledging *Chevron* deference rests upon a "fictionalized statement of legislative desire").

Start with a look to how our predecessors traditionally understood the judicial role in disputes over a law's meaning. From the Nation's founding, they considered "[t]he interpretation of the laws" in cases and controversies "the proper and peculiar province of the courts." The Federalist No. 78, p. 467 (C. Rossiter ed. 1961) (A. Hamilton). Perhaps the Court's most famous early decision reflected exactly that view. There, Chief Justice Marshall declared it "emphatically the province and duty of the judicial department to say what the law is." *Marbury*, 1 Cranch, at 177. For judges "have neither FORCE nor WILL but merely judgment"—and an obligation to exercise that judgment independently. The Federalist No. 78, at 465. No matter how "disagreeable that duty may be," this Court has said, a judge "is not at liberty to surrender, or to waive it." *United States* v. *Dickson*, 15 Pet. 141, 162 (1841) (Story, J.). This duty of independent judgment is perhaps "the defining characteristi[c] of Article III judges." *Stern* v. *Marshall*, 564 U. S. 462, 483 (2011).

To be sure, this Court has also long extended "great respect" to the "contemporaneous" and consistent views of the coordinate branches about the meaning of a statute's terms. *Edwards' Lessee* v. *Darby*, 12 Wheat. 206, 210 (1827); see also *McCulloch* v. *Maryland*, 4 Wheat. 316, 401 (1819); *Stuart* v. *Laird*, 1 Cranch 299, 309 (1803).[4] But traditionally, that did not mean a court had to "defer" to any "reasonable"

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[4] Accord, *National Lead Co.* v. *United States*, 252 U. S. 140, 145–146 (1920) (affording "great weight" to a "contemporaneous construction" by the executive that had "been long continued"); *Jacobs* v. *Prichard*, 223 U. S. 200, 214 (1912) ("find[ing] no ambiguity in the act" but also finding "strength" for the Court's interpretation in the executive's "immediate and continued construction of the act"); *Schell's Executors* v. *Fauché*, 138 U. S. 562, 572 (1891) (treating as "controlling" a "contemporaneous construction" of a law endorsed "not only [by] the courts but [also by] the departments").

construction of an "ambiguous" law that an executive agency might offer. It did not mean that the government could propound a "reasonable" view of the law's meaning one day, a different one the next, and bind the judiciary always to its latest word. Nor did it mean the executive could displace a pre-existing judicial construction of a statute's terms, replace it with its own, and effectively overrule a judicial precedent in the process. Put simply, this Court was "not bound" by any and all reasonable "administrative construction[s]" of ambiguous statutes when resolving cases and controversies. *Burnet* v. *Chicago Portrait Co.*, 285 U. S. 1, 16 (1932). While the executive's consistent and contemporaneous views warranted respect, they "by no means control[led] the action or the opinion of this court in expounding the law with reference to the rights of parties litigant before them." *Irvine* v. *Marshall*, 20 How. 558, 567 (1858); see also A. Bamzai, The Origins of Judicial Deference to Executive Interpretation, 126 Yale L. J. 908, 987 (2017).

Sensing how jarringly inconsistent *Chevron* is with this Court's many longstanding precedents discussing the nature of the judicial role in disputes over the law's meaning, the government and dissent struggle for a response. The best they can muster is a handful of cases from the early 1940s in which, they say, this Court first "put [deference] principles into action." *Post*, at 21 (KAGAN, J., dissenting). And, admittedly, for a period this Court toyed with a form of deference akin to *Chevron*, at least for so-called mixed questions of law and fact. See, *e.g.*, *Gray* v. *Powell*, 314 U. S. 402, 411–412 (1941); *NLRB* v. *Hearst Publications, Inc.*, 322 U. S. 111, 131 (1944). But, as the Court details, even that limited experiment did not last. See *ante*, at 10–12. Justice Roberts, in his *Gray* dissent, decried these decisions for "abdicat[ing our] function as a court of review" and "complete[ly] revers[ing] . . . the normal and usual method of construing a statute." 314 U. S., at 420–421. And just a few years later, in *Skidmore* v. *Swift & Co.*, 323

U. S. 134 (1944), the Court returned to its time-worn path.

Echoing themes that had run throughout our law from its start, Justice Robert H. Jackson wrote for the Court in *Skidmore*. There, he said, courts may extend respectful consideration to another branch's interpretation of the law, but the weight due those interpretations must always "depend upon the[ir] thoroughness . . . , the validity of [their] reasoning, [their] consistency with earlier and later pronouncements, and all those factors which give [them] power to persuade." *Id.*, at 140. In another case the same year, and again writing for the Court, Justice Jackson expressly rejected a call for a judge-made doctrine of deference much like *Chevron*, offering that, "[i]f Congress had deemed it necessary or even appropriate" for courts to "defe[r] to administrative construction[,] . . . it would not have been at a loss for words to say so." *Davies Warehouse Co.* v. *Bowles*, 321 U. S. 144, 156 (1944).

To the extent proper respect for precedent demands, as it always has, special respect for longstanding and mainstream decisions, *Chevron* scores badly. It represented not a continuation of a long line of decisions but a break from them. Worse, it did not merely depart from our precedents. More nearly, *Chevron* defied them.

2

Consider next how uneasily *Chevron* deference sits alongside so many other settled aspects of our law. Having witnessed first-hand King George's efforts to gain influence and control over colonial judges, see Declaration of Independence ¶ 11, the framers made a considered judgment to build judicial independence into the Constitution's design. They vested the judicial power in decisionmakers with life tenure. Art. III, §1. They placed the judicial salary beyond political control during a judge's tenure. *Ibid.* And they rejected any proposal that would subject judicial decisions to review by political actors. The Federalist No. 81, at 482;

United States v. *Hansen*, 599 U. S. 762, 786–791 (2023) (THOMAS, J., concurring). All of this served to ensure the same thing: "A fair trial in a fair tribunal." *In re Murchison*, 349 U. S. 133, 136 (1955). One in which impartial judges, not those currently wielding power in the political branches, would "say what the law is" in cases coming to court. *Marbury*, 1 Cranch, at 177.

Chevron deference undermines all that. It precludes courts from exercising the judicial power vested in them by Article III to say what the law is. It forces judges to abandon the best reading of the law in favor of views of those presently holding the reins of the Executive Branch. It requires judges to change, and change again, their interpretations of the law as and when the government demands. And that transfer of power has exactly the sort of consequences one might expect. Rather than insulate adjudication from power and politics to ensure a fair hearing "without respect to persons" as the federal judicial oath demands, 28 U. S. C. §453, *Chevron* deference requires courts to "place a finger on the scales of justice in favor of the most powerful of litigants, the federal government." *Buffington*, 598 U. S., at ___ (slip op., at 9). Along the way, *Chevron* deference guarantees "systematic bias" in favor of whichever political party currently holds the levers of executive power. P. Hamburger, *Chevron* Bias, 84 Geo. Wash. L. Rev. 1187, 1212 (2016).

Chevron deference undermines other aspects of our settled law, too. In this country, we often boast that the Constitution's promise of due process of law, see Amdts. 5, 14, means that "'no man can be a judge in his own case.'" *Williams* v. *Pennsylvania*, 579 U. S. 1, 8–9 (2016); *Calder* v. *Bull*, 3 Dall. 386, 388 (1798) (opinion of Chase, J.). That principle, of course, has even deeper roots, tracing far back into the common law where it was known by the Latin maxim *nemo iudex in causa sua*. See 1 E. Coke, Institutes

of the Laws of England §212, *141a. Yet, under the *Chevron* regime, all that means little, for executive agencies may effectively judge the scope of their own lawful powers. See, *e.g., Arlington* v. *FCC*, 569 U. S. 290, 296–297 (2013).

Traditionally, as well, courts have sought to construe statutes as a reasonable reader would "when the law was made." Blackstone 59; see *United States* v. *Fisher*, 2 Cranch 358, 386 (1805). Today, some call this "textualism." But really it's a very old idea, one that constrains judges to a lawfinding rather than lawmaking role by focusing their work on the statutory text, its linguistic context, and various canons of construction. In that way, textualism serves as an essential guardian of the due process promise of fair notice. If a judge could discard an old meaning and assign a new one to a law's terms, all without any legislative revision, how could people ever be sure of the rules that bind them? *New Prime Inc.* v. *Oliveira*, 586 U. S. 105, 113 (2019). Were the rules otherwise, Blackstone warned, the people would be rendered "slaves to their magistrates." 4 Blackstone 371.

Yet, replace "magistrates" with "bureaucrats," and Blackstone's fear becomes reality when courts employ *Chevron* deference. Whenever we confront an ambiguity in the law, judges do not seek to resolve it impartially according to the best evidence of the law's original meaning. Instead, we resort to a far cruder heuristic: "The reasonable bureaucrat always wins." And because the reasonable bureaucrat may change his mind year-to-year and election-to-election, the people can never know with certainty what new "interpretations" might be used against them. This "fluid" approach to statutory interpretation is "as much a trap for the innocent as the ancient laws of Caligula," which were posted so high up on the walls and in print so small that ordinary people could never be sure what they required. *United States* v. *Cardiff*, 344 U. S. 174, 176 (1952).

The ancient rule of lenity is still another of *Chevron*'s victims. Since the founding, American courts have construed ambiguities in penal laws against the government and with lenity toward affected persons. *Wooden* v. *United States*, 595 U. S. 360, 388–390 (2022) (GORSUCH, J., concurring in judgment). That principle upholds due process by safeguarding individual liberty in the face of ambiguous laws. *Ibid.* And it fortifies the separation of powers by keeping the power of punishment firmly "'in the legislative, not in the judicial department.'" *Id.*, at 391 (quoting *United States* v. *Wiltberger*, 5 Wheat. 76, 95 (1820)). But power begets power. And pressing *Chevron* deference as far as it can go, the government has sometimes managed to leverage "ambiguities" in the written law to penalize conduct Congress never clearly proscribed. Compare *Guedes* v. *ATF*, 920 F. 3d 1, 27–28, 31 (CADC 2019), with *Garland* v. *Cargill*, 602 U. S. 604 (2024).

In all these ways, *Chevron*'s fiction has led us to a strange place. One where authorities long thought reserved for Article III are transferred to Article II, where the scales of justice are tilted systematically in favor of the most powerful, where legal demands can change with every election even though the laws do not, and where the people are left to guess about their legal rights and responsibilities. So much tension with so many foundational features of our legal order is surely one more sign that we have "taken a wrong turn along the way." *Kisor* v. *Wilkie*, 588 U. S. 558, 607 (2019) (GORSUCH, J., concurring in judgment).[5]

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[5] The dissent suggests that *Chevron* deference bears at least something in common with surrounding law because it resembles a presumption or traditional canon of construction, and both "are common." *Post*, at 8, n. 1, 28–29 (opinion of KAGAN, J.). But even that thin reed wavers at a glance. Many of the presumptions and interpretive canons the dissent cites—including lenity, *contra proferentem*, and others besides—"'embod[y] . . . legal doctrine[s] centuries older than our Republic.'" *Opati* v. *Republic of Sudan*, 590 U. S. 418, 425 (2020). *Chevron* deference can make no such boast. Many of the presumptions and canons the dissent cites also

Finally, consider workability and reliance. If, as I have sought to suggest, these factors may sometimes serve as useful proxies for the question whether a precedent comports with the historic tide of judicial practice or represents an aberrational mistake, see Part I–C, *supra*, they certainly do here.

Take *Chevron*'s "workability." Throughout its short life, this Court has been forced to supplement and revise *Chevron* so many times that no one can agree on how many "steps" it requires, nor even what each of those "steps" entails. Some suggest that the analysis begins with "step zero" (perhaps itself a tell), an innovation that traces to *United States* v. *Mead Corp.*, 533 U. S. 218. *Mead* held that, before even considering whether *Chevron* applies, a court must determine whether Congress meant to delegate to the agency authority to interpret the law in a given field. 533 U. S., at 226–227. But that exercise faces an immediate challenge: Because *Chevron* depends on a judicially implied, rather than a legislatively expressed, delegation of interpretive authority to an executive agency, Part II–A, *supra*, when should the fiction apply and when not? *Mead* fashioned a multifactor test for judges to use. 533 U. S., at

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serve the Constitution, protecting the lines of authority it draws. Take just two examples: The federalism canon tells courts to presume federal statutes do not preempt state laws because of the sovereignty States enjoy under the Constitution. *Bond* v. *United States*, 572 U. S. 844, 858 (2014). The presumption against retroactivity serves as guardian of the Constitution's promise of due process and its ban on *ex post facto* laws, *Landgraf* v. *USI Film Products*, 511 U. S. 244, 265 (1994). Once more, however, *Chevron* deference can make no similar claim. Rather than serve the Constitution's usual rule that litigants are entitled to have an independent judge interpret disputed legal terms, *Chevron* deference works to undermine that promise. As explored above, too, *Chevron* deference sits in tension with many traditional legal presumptions and interpretive principles, representing nearly the *inverse* of the rules of lenity, *nemo iudex*, and *contra proferentem*.

229–231. But that test has proved as indeterminate in application as it was contrived in origin. Perhaps for these reasons, perhaps for others, this Court has sometimes applied *Mead* and often ignored it. See *Brand X*, 545 U. S., at 1014, n. 8 (Scalia, J., dissenting).

Things do not improve as we move up the *Chevron* ladder. At "step one," a judge must defer to an executive official's interpretation when the statute at hand is "ambiguous." But even today, *Chevron*'s principal beneficiary—the federal government—still cannot say when a statute is sufficiently ambiguous to trigger deference. See, *e.g.*, Tr. of Oral Arg. in *American Hospital Assn.* v. *Becerra*, O. T. 2021, No. 20–1114, pp. 71–72. Perhaps thanks to this particular confusion, the search for ambiguity has devolved into a sort of Snark hunt: Some judges claim to spot it almost everywhere, while other equally fine judges claim never to have seen it. Compare L. Silberman, *Chevron*—The Intersection of Law & Policy, 58 Geo. Wash. L. Rev. 821, 826 (1990), with R. Kethledge, Ambiguities and Agency Cases: Reflections After (Almost) Ten Years on the Bench, 70 Vand. L. Rev. En Banc 315, 323 (2017).

Nor do courts agree when it comes to "step two." There, a judge must assess whether an executive agency's interpretation of an ambiguous statute is "reasonable." But what does that inquiry demand? Some courts engage in a comparatively searching review; others almost reflexively defer to an agency's views. Here again, courts have pursued "wildly different" approaches and reached wildly different conclusions in similar cases. See B. Kavanaugh, Fixing Statutory Interpretation, 129 Harv. L. Rev. 2118, 2152 (2016) (Kavanaugh).

Today's cases exemplify some of these problems. We have before us two circuit decisions, three opinions, and at least as many interpretive options on the *Chevron* menu. On the one hand, we have the D. C. Circuit majority, which deemed the Magnuson-Stevens Act "ambiguous" and upheld the

agency's regulation as "'permissible.'" 45 F. 4th 359, 365 (2022). On the other hand, we have the D. C. Circuit dissent, which argues the statute is "unambiguou[s]" and that it plainly forecloses the agency's new rule. *Id.*, at 372 (opinion of Walker, J.). And on yet a third hand, we have the First Circuit, which claimed to have identified "clear textual support" for the regulation, yet refused to say whether it would "classify [its] conclusion as a product of *Chevron* step one or step two." 62 F. 4th 621, 631, 634 (2023). As these cases illustrate, *Chevron* has turned statutory interpretation into a game of bingo under blindfold, with parties guessing at how many boxes there are and which one their case might ultimately fall in.

Turn now from workability to reliance. Far from engendering reliance interests, the whole point of *Chevron* deference is to upset them. Under *Chevron*, executive officials can replace one "reasonable" interpretation with another at any time, all without any change in the law itself. The result: Affected individuals "can never be sure of their legal rights and duties." *Buffington*, 598 U. S., at ___ (slip op., at 12).

How bad is the problem? Take just one example. *Brand X* concerned a law regulating broadband internet services. There, the Court upheld an agency rule adopted by the administration of President George W. Bush because it was premised on a "reasonable" interpretation of the statute. Later, President Barack Obama's administration rescinded the rule and replaced it with another. Later still, during President Donald J. Trump's administration, officials replaced that rule with a different one, all before President Joseph R. Biden, Jr.'s administration declared its intention to reverse course for yet a fourth time. See Safeguarding and Securing the Open Internet, 88 Fed. Reg. 76048 (2023); *Brand X*, 545 U. S., at 981–982. Each time, the government claimed its new rule was just as "reasonable" as the last. Rather than promoting reliance by fixing the meaning of

the law, *Chevron* deference engenders constant uncertainty and convulsive change even when the statute at issue itself remains unchanged.

Nor are these antireliance harms distributed equally. Sophisticated entities and their lawyers may be able to keep pace with rule changes affecting their rights and responsibilities. They may be able to lobby for new "'reasonable'" agency interpretations and even capture the agencies that issue them. *Buffington*, 598 U. S., at ___, ___ (slip op., at 8, 13). But ordinary people can do none of those things. They are the ones who suffer the worst kind of regulatory whiplash *Chevron* invites.

Consider a couple of examples. Thomas Buffington, a veteran of the U. S. Air Force, was injured in the line of duty. For a time after he left the Air Force, the Department of Veterans Affairs (VA) paid disability benefits due him by law. But later the government called on Mr. Buffington to reenter active service. During that period, everyone agreed, the VA could (as it did) suspend his disability payments. After he left active service for a second time, however, the VA turned his patriotism against him. By law, Congress permitted the VA to suspend disability pay only "for any period for which [a servicemember] receives active service pay." 38 U. S. C. §5304(c). But the VA had adopted a self-serving regulation requiring veterans to file a form asking for the resumption of their disability pay after a second (or subsequent) stint in active service. 38 CFR §3.654(b)(2) (2021). Unaware of the regulation, Mr. Buffington failed to reapply immediately. When he finally figured out what had happened and reapplied, the VA agreed to resume payments going forward but refused to give Mr. Buffington all of the past disability payments it had withheld. *Buffington*, 598 U. S., at ___–___ (slip op., at 1–4).

Mr. Buffington challenged the agency's action as inconsistent with Congress's direction that the VA may suspend disability payments only for those periods when a veteran

returns to active service. But armed with *Chevron*, the agency defeated Mr. Buffington's claim. Maybe the self-serving regulation the VA cited as justification for its action was not premised on the best reading of the law, courts said, but it represented a "'permissible'" one. 598 U. S., at ___ (slip op., at 7). In that way, the Executive Branch was able to evade Congress's promises to someone who took the field repeatedly in the Nation's defense.

In another case, one which I heard as a court of appeals judge, *De Niz Robles* v. *Lynch*, 803 F. 3d 1165 (CA10 2015), the Board of Immigration Appeals invoked *Chevron* to overrule a judicial precedent on which many immigrants had relied, see *In re Briones*, 24 I. & N. Dec. 355, 370 (BIA 2007) (purporting to overrule *Padilla–Caldera* v. *Gonzales*, 426 F. 3d 1294 (CA10 2005)). The agency then sought to apply its new interpretation retroactively to punish those immigrants—including Alfonzo De Niz Robles, who had relied on that judicial precedent as authority to remain in this country with his U. S. wife and four children. See 803 F. 3d, at 1168–1169. Our court ruled that this retrospective application of the BIA's new interpretation of the law violated Mr. De Niz Robles's due process rights. *Id.*, at 1172. But as a lower court, we could treat only the symptom, not the disease. So *Chevron* permitted the agency going forward to overrule a judicial decision about the best reading of the law with its own different "reasonable" one and in that way deny relief to countless future immigrants.

Those are just two stories among so many that federal judges could tell (and have told) about what *Chevron* deference has meant for ordinary people interacting with the federal government. See, *e.g.*, *Lambert* v. *Saul*, 980 F. 3d 1266, 1268–1276 (CA9 2020); *Valent* v. *Commissioner of Social Security*, 918 F. 3d 516, 525–527 (CA6 2019) (Kethledge, J., dissenting); *Gonzalez* v. *United States Atty. Gen.*, 820 F. 3d 399, 402–405 (CA11 2016) (*per curiam*).

What does the federal government have to say about this?

It acknowledges that *Chevron* sits as a heavy weight on the scale in favor of the government, "oppositional" to many "categories of individuals." Tr. of Oral Arg. in No. 22–1219, p. 133 (Relentless Tr.). But, according to the government, *Chevron* deference is too important an innovation to undo. In its brief reign, the government says, it has become a "fundamenta[l] . . . ground rul[e] for how all three branches of the government are operating together." Relentless Tr. 102. But, in truth, the Constitution, the APA, and our longstanding precedents set those ground rules some time ago. And under them, agencies cannot invoke a judge-made fiction to unsettle our Nation's promise to individuals that they are entitled to make their arguments about the law's demands on them in a fair hearing, one in which they stand on equal footing with the government before an independent judge.

C

How could a Court, guided for 200 years by Chief Justice Marshall's example, come to embrace a counter-*Marbury* revolution, one at war with the APA, time honored precedents, and so much surrounding law? To answer these questions, turn to Lesson 3 and witness the temptation to endow a stray passage in a judicial decision with extraordinary authority. Call it "power quoting."

Chevron was an unlikely place for a revolution to begin. The case concerned the Clean Air Act's requirement that States regulate "stationary sources" of air pollution in their borders. See 42 U. S. C. §7401 *et seq*. At the time, it was an open question whether entire industrial plants or their constituent polluting parts counted as "stationary sources." The Environmental Protection Agency had defined entire plants as sources, an approach that allowed companies to replace individual plant parts without automatically triggering the permitting requirements that apply to new sources. *Chevron*, 467 U. S., at 840.

This Court upheld the EPA's definition as consistent with the governing statute. *Id.*, at 866. The decision, issued by a bare quorum of the Court, without concurrence or dissent, purported to apply "well-settled principles." *Id.*, at 845. "If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue," *Chevron* provided, then "that intention is the law and must be given effect." *Id.*, at 843, n. 9. Many of the cases *Chevron* cited to support its judgment stood for the traditional proposition that courts afford respectful consideration, not deference, to executive interpretations of the law. See, *e.g.*, *Burnet*, 285 U. S., at 16; *United States* v. *Moore*, 95 U. S. 760, 763 (1878). And the decision's sole citation to legal scholarship was to Roscoe Pound, who long championed *de novo* judicial review. 467 U. S., at 843, n. 10; see R. Pound, The Place of the Judiciary in a Democratic Polity, 27 A. B. A. J. 133, 136–137 (1941).

At the same time, of course, the opinion contained bits and pieces that spoke differently. The decision also said that, "if [a] statute is silent or ambiguous with respect to [a] specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." 467 U. S., at 843. But it seems the government didn't advance this formulation in its brief, so there was no adversarial engagement on it. T. Merrill, The Story of *Chevron*: The Making of an Accidental Landmark, 66 Admin. L. Rev. 253, 268 (2014) (Merrill). As we have seen, too, the Court did not pause to consider (or even mention) the APA. See Part II–A, *supra.* It did not discuss contrary precedents issued by the Court since the founding, let alone purport to overrule any of them. See Part II–B–1, *supra.* Nor did the Court seek to address how its novel rule of deference might be squared with so much surrounding law. See Part II–B–2, *supra.* As even its defenders have acknowledged, "*Chevron* barely bothered to justify its rule of deference, and the few brief passages on this matter pointed in disparate

directions." Kagan 212–213. "[T]he quality of the reasoning," they acknowledge, "was not high," C. Sunstein, *Chevron* as Law, 107 Geo. L. J. 1613, 1669 (2019).

If *Chevron* meant to usher in a revolution in how judges interpret laws, no one appears to have realized it at the time. *Chevron*'s author, Justice Stevens, characterized the decision as a "simpl[e] . . . restatement of existing law, nothing more or less." Merrill 255, 275. In the "19 argued cases" in the following Term "that presented some kind of question about whether the Court should defer to an agency interpretation of statutory law," this Court cited *Chevron* just once. Merrill 276. By some accounts, the decision seemed "destined to obscurity." *Ibid.*

It was only three years later when Justice Scalia wrote a concurrence that a revolution began to take shape. *Buffington*, 598 U. S., at ___ (slip op., at 8). There, he argued for a new rule requiring courts to defer to executive agency interpretations of the law whenever a "'statute is silent or ambiguous.'" *NLRB* v. *Food & Commercial Workers*, 484 U. S. 112, 133–134 (1987) (opinion of Scalia, J.). Eventually, a majority of the Court followed his lead. *Buffington*, 598 U. S., at ___ (slip op., at 8). But from the start, Justice Scalia made no secret about the scope of his ambitions. See Judicial Deference to Administrative Interpretations of Law, 1989 Duke L. J. 511, 521 (1989) (Scalia). The rule he advocated for represented such a sharp break from prior practice, he explained, that many judges of his day didn't yet "understand" the "old criteria" were "no longer relevant." *Ibid.* Still, he said, overthrowing the past was worth it because a new deferential rule would be "easier to follow." *Ibid.*

Events proved otherwise. As the years wore on and the Court's new and aggressive reading of *Chevron* gradually exposed itself as unworkable, unfair, and at odds with our separation of powers, Justice Scalia could have doubled down on the project. But he didn't. He appreciated that

stare decisis is not a rule of "if I thought it yesterday, I must think it tomorrow." And rather than cling to the pride of personal precedent, the Justice began to express doubts over the very project that he had worked to build. See *Perez* v. *Mortgage Bankers Assn.*, 575 U. S. 92, 109–110 (2015) (opinion concurring in judgment); cf. *Decker* v. *Northwest Environmental Defense Center*, 568 U. S. 597, 617–618, 621 (2013) (opinion concurring in part and dissenting in part). If *Chevron*'s ascent is a testament to the Justice's ingenuity, its demise is an even greater tribute to his humility.[6]

Justice Scalia was not alone in his reconsideration. After years spent laboring under *Chevron*, trying to make sense of it and make it work, Member after Member of this Court came to question the project. See, *e.g.*, *Pereira* v. *Sessions*, 585 U. S. 198, 219–221 (2018) (Kennedy, J., concurring); *Michigan* v. *EPA*, 576 U. S. 743, 760–764 (2015) (THOMAS, J., concurring); *Kisor*, 588 U. S., at 591 (ROBERTS, C. J., concurring in part); *Gutierrez-Brizuela*, 834 F. 3d, at 1153; *Buffington*, 598 U. S., at ___–___ (slip op., at 14–15); Kavanaugh 2150–2154. Ultimately, the Court gave up. Despite repeated invitations, it has not applied *Chevron* deference since 2016. Relentless Tr. 81; App. to Brief for Respondents in No. 22–1219, p. 68a. So an experiment that began only in the mid-1980s effectively ended eight years ago. Along the way, an unusually large number of federal appellate judges voiced their own thoughtful and extensive

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[6] It should be recalled that, when Justice Scalia launched the *Chevron* revolution, there were many judges who "abhor[red] . . . 'plain meaning'" and preferred instead to elevate "legislative history" and their own curated accounts of a law's "purpose[s]" over enacted statutory text. Scalia 515, 521. *Chevron*, he predicted, would provide a new guardrail against that practice. Scalia 515, 521. As the Justice's later writings show, he had the right diagnosis, just the wrong cure. The answer for judges eliding statutory terms is not deference to agencies that may seek to do the same, but a demand that all return to a more faithful adherence to the written law. That was, of course, another project Justice Scalia championed. And as we like to say, "we're all textualists now."

criticisms of *Chevron*. *Buffington*, 598 U. S., at ___–___ (slip op., at 14–15) (collecting examples). A number of state courts did, too, refusing to import *Chevron* deference into their own administrative law jurisprudence. See 598 U. S., at ___ (slip op., at 15).

Even if all that and everything else laid out above is true, the government suggests we should retain *Chevron* deference because judges simply cannot live without it; some statutes are just too "technical" for courts to interpret "intelligently." *Post*, at 9, 32 (dissenting opinion). But that objection is no answer to *Chevron*'s inconsistency with Congress's directions in the APA, so much surrounding law, or the challenges its multistep regime have posed in practice. Nor does history counsel such defeatism. Surely, it would be a mistake to suggest our predecessors before *Chevron*'s rise in the mid-1980s were unable to make their way intelligently through technical statutory disputes. Following their lead, over the past eight years this Court has managed to resolve even highly complex cases without *Chevron* deference, and done so even when the government sought deference. Nor, as far as I am aware, did any Member of the Court suggest *Chevron* deference was necessary to an intelligent resolution of any of those matters.[7] If anything, by affording *Chevron* deference a period of repose before addressing whether it should be retained, the Court has enabled its Members to test the propriety of that precedent and reflect more deeply on how well it fits into the broader architecture of our law. Others may see things differently, see *post*, at 26–27 (dissenting opinion), but the caution the

[7] See, *e.g., Becerra* v. *Empire Health Foundation, for Valley Hospital Medical Center*, 597 U. S. 424, 434 (2022) (resolving intricate Medicare dispute by reference solely to "text," "context," and "structure"); see also *Sackett* v. *EPA*, 598 U. S. 651 (2023) (same in a complex Clean Water Act dispute); *Johnson* v. *Guzman Chavez*, 594 U. S. 523 (2021) (same in technical immigration case).

Court has exhibited before overruling *Chevron* may illustrate one of the reasons why the current Court has been slower to overrule precedents than some of its predecessors, see Part I–C, *supra*.

None of this, of course, discharges any Member of this Court from the task of deciding for himself or herself today whether *Chevron* deference itself warrants deference. But when so many past and current judicial colleagues in this Court and across the country tell us our doctrine is misguided, and when we ourselves managed without *Chevron* for centuries and manage to do so today, the humility at the core of *stare decisis* compels us to pause and reflect carefully on the wisdom embodied in that experience. And, in the end, to my mind the lessons of experience counsel wisely against continued reliance on *Chevron*'s stray and unconsidered digression. This Court's opinions fill over 500 volumes, and perhaps "some printed judicial word may be found to support almost any plausible proposition." R. Jackson, Decisional Law and Stare Decisis, 30 A. B. A. J. 334 (1944). It is not for us to pick and choose passages we happen to like and demand total obedience to them in perpetuity. That would turn *stare decisis* from a doctrine of humility into a tool for judicial opportunism. *Brown*, 596 U. S., at 141.

III

Proper respect for precedent helps "keep the scale of justice even and steady," by reinforcing decisional rules consistent with the law upon which all can rely. 1 Blackstone 69. But that respect does not require, nor does it readily tolerate, a steadfast refusal to correct mistakes. As early as 1810, this Court had already overruled one of its cases. See *Hudson* v. *Guestier*, 6 Cranch 281, 284 (overruling *Rose* v. *Himely*, 4 Cranch 241 (1808)). In recent years, the Court may have overruled precedents less frequently than it did during the Warren and Burger Courts. See Part I–C, *supra*.

But the job of reconsidering past decisions remains one every Member of this Court faces from time to time.[8]

Justice William O. Douglas served longer on this Court than any other person in the Nation's history. During his tenure, he observed how a new colleague might be inclined initially to "revere" every word written in an opinion issued before he arrived. W. Douglas, Stare Decisis, 49 Colum. L. Rev. 735, 736 (1949). But, over time, Justice Douglas reflected, his new colleague would "remembe[r] . . . that it is the Constitution which he swore to support and defend, not the gloss which his predecessors may have put on it." *Ibid.* And "[s]o he [would] com[e] to formulate his own views, rejecting some earlier ones as false and embracing others." *Ibid.* This process of reexamination, Justice Douglas explained, is a "necessary consequence of our system" in which each judge takes an oath—both "personal" and binding—to discern the law's meaning for himself and apply it faithfully in the cases that come before him. *Id.*, at 736–737.

Justice Douglas saw, too, how appeals to precedent could be overstated and sometimes even overwrought. Judges, he reflected, would sometimes first issue "new and startling decision[s]," and then later spin around and "acquire an acute conservatism" in their aggressive defense of "their

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[8] Today's dissenters are no exceptions. They have voted to overrule precedents that they consider "wrong," *Hurst* v. *Florida*, 577 U. S. 92, 101 (2016) (opinion for the Court by SOTOMAYOR, J., joined by, *inter alios*, KAGAN, J.); *Obergefell* v. *Hodges*, 576 U. S. 644, 665, 675 (2015) (opinion for the Court, joined by, *inter alios*, SOTOMAYOR and KAGAN, JJ.); that conflict with the Constitution's "original meaning," *Alleyne* v. *United States*, 570 U. S. 99, 118 (2013) (SOTOMAYOR, J., joined by, *inter alias*, KAGAN, J., concurring); and that have proved "unworkable," *Johnson* v. *United States*, 576 U. S. 591, 605 (2015) (opinion for the Court, joined by, *inter alios*, SOTOMAYOR and KAGAN, JJ.); see also *Erlinger* v. *United States*, 602 U. S. ___, ___ (2024) (JACKSON, J., dissenting) (slip op., at 1) (arguing *Apprendi* v. *New Jersey*, 530 U. S. 466 (2000), and the many cases applying it were all "wrongly decided").

new *status quo*." *Id.*, at 737. In that way, even the most novel and unlikely decisions became "coveted anchorage[s]," defended heatedly, if ironically, under the banner of "*stare decisis*." *Ibid.*; see also *Edwards* v. *Vannoy*, 593 U. S. 255, 294, n. 7 (2021) (GORSUCH, J., concurring).

That is *Chevron*'s story: A revolution masquerading as the status quo. And the defense of it follows the same course Justice Douglas described. Though our dissenting colleagues have not hesitated to question other precedents in the past, they today manifest what Justice Douglas called an "acute conservatism" for *Chevron*'s "startling" development, insisting that if this "coveted anchorage" is abandoned the heavens will fall. But the Nation managed to live with busy executive agencies of all sorts long before the *Chevron* revolution began to take shape in the mid-1980s. And all today's decision means is that, going forward, federal courts will do exactly as this Court has since 2016, exactly as it did before the mid-1980s, and exactly as it had done since the founding: resolve cases and controversies without any systemic bias in the government's favor.

Proper respect for precedent does not begin to suggest otherwise. Instead, it counsels respect for the written law, adherence to consistent teachings over aberrations, and resistance to the temptation of treating our own stray remarks as if they were statutes. And each of those lessons points toward the same conclusion today: *Chevron* deference is inconsistent with the directions Congress gave us in the APA. It represents a grave anomaly when viewed against the sweep of historic judicial practice. The decision undermines core rule-of-law values ranging from the promise of fair notice to the promise of a fair hearing. Even on its own terms, it has proved unworkable and operated to undermine rather than advance reliance interests, often to the detriment of ordinary Americans. And from the start, the whole project has relied on the overaggressive use of snippets and stray remarks from an opinion that carried

mixed messages. *Stare decisis*'s true lesson today is not that we are bound to respect *Chevron*'s "startling development," but bound to inter it.

SUPREME COURT OF THE UNITED STATES

Nos. 22–451 and 22–1219

LOPER BRIGHT ENTERPRISES, ET AL.,
PETITIONERS
22–451 *v.*
GINA RAIMONDO, SECRETARY OF
COMMERCE, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

RELENTLESS, INC., ET AL., PETITIONERS
22–1219 *v.*
DEPARTMENT OF COMMERCE, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

[June 28, 2024]

JUSTICE KAGAN, with whom JUSTICE SOTOMAYOR and JUSTICE JACKSON join,* dissenting.

For 40 years, *Chevron U. S. A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U. S. 837 (1984), has served as a cornerstone of administrative law, allocating responsibility for statutory construction between courts and agencies. Under *Chevron*, a court uses all its normal interpretive tools to determine whether Congress has spoken to an issue. If the court finds Congress has done so, that is the end of the matter; the agency's views make no difference. But if the court finds, at the end of its interpretive work, that

*JUSTICE JACKSON did not participate in the consideration or decision of the case in No. 22–451 and joins this opinion only as it applies to the case in No. 22–1219.

Congress has left an ambiguity or gap, then a choice must be made. Who should give content to a statute when Congress's instructions have run out? Should it be a court? Or should it be the agency Congress has charged with administering the statute? The answer *Chevron* gives is that it should usually be the agency, within the bounds of reasonableness. That rule has formed the backdrop against which Congress, courts, and agencies—as well as regulated parties and the public—all have operated for decades. It has been applied in thousands of judicial decisions. It has become part of the warp and woof of modern government, supporting regulatory efforts of all kinds—to name a few, keeping air and water clean, food and drugs safe, and financial markets honest.

And the rule is right. This Court has long understood *Chevron* deference to reflect what Congress would want, and so to be rooted in a presumption of legislative intent. Congress knows that it does not—in fact cannot—write perfectly complete regulatory statutes. It knows that those statutes will inevitably contain ambiguities that some other actor will have to resolve, and gaps that some other actor will have to fill. And it would usually prefer that actor to be the responsible agency, not a court. Some interpretive issues arising in the regulatory context involve scientific or technical subject matter. Agencies have expertise in those areas; courts do not. Some demand a detailed understanding of complex and interdependent regulatory programs. Agencies know those programs inside-out; again, courts do not. And some present policy choices, including trade-offs between competing goods. Agencies report to a President, who in turn answers to the public for his policy calls; courts have no such accountability and no proper basis for making policy. And of course Congress has conferred on that expert, experienced, and politically accountable agency the authority to administer—to make rules about and otherwise implement—the statute giving rise to the ambiguity or

gap. Put all that together and deference to the agency is the almost obvious choice, based on an implicit congressional delegation of interpretive authority. We defer, the Court has explained, "because of a presumption that Congress" would have "desired the agency (rather than the courts)" to exercise "whatever degree of discretion" the statute allows. *Smiley* v. *Citibank (South Dakota), N. A.*, 517 U. S. 735, 740–741 (1996).

Today, the Court flips the script: It is now "the courts (rather than the agency)" that will wield power when Congress has left an area of interpretive discretion. A rule of judicial humility gives way to a rule of judicial hubris. In recent years, this Court has too often taken for itself decision-making authority Congress assigned to agencies. The Court has substituted its own judgment on workplace health for that of the Occupational Safety and Health Administration; its own judgment on climate change for that of the Environmental Protection Agency; and its own judgment on student loans for that of the Department of Education. See, *e.g.*, *National Federation of Independent Business* v. *OSHA*, 595 U. S. 109 (2022); *West Virginia* v. *EPA*, 597 U. S. 697 (2022); *Biden* v. *Nebraska*, 600 U. S. 477 (2023). But evidently that was, for this Court, all too piecemeal. In one fell swoop, the majority today gives itself exclusive power over every open issue—no matter how expertise-driven or policy-laden—involving the meaning of regulatory law. As if it did not have enough on its plate, the majority turns itself into the country's administrative czar. It defends that move as one (suddenly) required by the (nearly 80-year-old) Administrative Procedure Act. But the Act makes no such demand. Today's decision is not one Congress directed. It is entirely the majority's choice.

And the majority cannot destroy one doctrine of judicial humility without making a laughing-stock of a second. (If opinions had titles, a good candidate for today's would be Hubris Squared.) *Stare decisis* is, among other things, a

way to remind judges that wisdom often lies in what prior judges have done. It is a brake on the urge to convert "every new judge's opinion" into a new legal rule or regime. *Dobbs* v. *Jackson Women's Health Organization*, 597 U. S. 215, 388 (2022) (joint opinion of Breyer, SOTOMAYOR, and KAGAN, JJ., dissenting) (quoting 1 W. Blackstone, Commentaries on the Laws of England 69 (7th ed. 1775)). *Chevron* is entrenched precedent, entitled to the protection of *stare decisis*, as even the majority acknowledges. In fact, *Chevron* is entitled to the supercharged version of that doctrine because Congress could always overrule the decision, and because so many governmental and private actors have relied on it for so long. Because that is so, the majority needs a "particularly special justification" for its action. *Kisor* v. *Wilkie*, 588 U. S. 558, 588 (2019) (opinion of the Court). But the majority has nothing that would qualify. It barely tries to advance the usual factors this Court invokes for overruling precedent. Its justification comes down, in the end, to this: Courts must have more say over regulation—over the provision of health care, the protection of the environment, the safety of consumer products, the efficacy of transportation systems, and so on. A longstanding precedent at the crux of administrative governance thus falls victim to a bald assertion of judicial authority. The majority disdains restraint, and grasps for power.

I

Begin with the problem that gave rise to *Chevron* (and also to its older precursors): The regulatory statutes Congress passes often contain ambiguities and gaps. Sometimes they are intentional. Perhaps Congress "consciously desired" the administering agency to fill in aspects of the legislative scheme, believing that regulatory experts would be "in a better position" than legislators to do so. *Chevron*, 467 U. S., at 865. Or "perhaps Congress was unable to forge a coalition on either side" of a question, and the contending

parties "decided to take their chances with" the agency's resolution. *Ibid.* Sometimes, though, the gaps or ambiguities are what might be thought of as predictable accidents. They may be the result of sloppy drafting, a not infrequent legislative occurrence. Or they may arise from the well-known limits of language or foresight. Accord, *ante*, at 7, 22. "The subject matter" of a statutory provision may be too "specialized and varying" to "capture in its every detail." *Kisor*, 588 U. S., at 566 (plurality opinion). Or the provision may give rise, years or decades down the road, to an issue the enacting Congress could not have anticipated. Whichever the case—whatever the reason—the result is to create uncertainty about some aspect of a provision's meaning.

Consider a few examples from the caselaw. They will help show what a typical *Chevron* question looks like—or really, what a typical *Chevron* question *is*. Because when choosing whether to send some class of questions mainly to a court, or mainly to an agency, abstract analysis can only go so far; indeed, it may obscure what matters most. So I begin with the concrete:

- Under the Public Health Service Act, the Food and Drug Administration (FDA) regulates "biological product[s]," including "protein[s]." 42 U. S. C. §262(i)(1). When does an alpha amino acid polymer qualify as such a "protein"? Must it have a specific, defined sequence of amino acids? See *Teva Pharmaceuticals USA, Inc.* v. *FDA*, 514 F. Supp. 3d 66, 79–80, 93–106 (DC 2020).
- Under the Endangered Species Act, the Fish and Wildlife Service must designate endangered "vertebrate fish or wildlife" species, including "distinct population segment[s]" of those species. 16 U. S. C. §1532(16); see §1533. What makes one population segment "distinct" from another? Must the Service treat the Washington State population of western gray squirrels as "distinct"

because it is geographically separated from other western gray squirrels? Or can the Service take into account that the genetic makeup of the Washington population does not differ markedly from the rest? See *Northwest Ecosystem Alliance* v. *United States Fish and Wildlife Serv.*, 475 F. 3d 1136, 1140–1145, 1149 (CA9 2007).

- Under the Medicare program, reimbursements to hospitals are adjusted to reflect "differences in hospital wage levels" across "geographic area[s]." 42 U. S. C. §1395ww(d)(3)(E)(i). How should the Department of Health and Human Services measure a "geographic area"? By city? By county? By metropolitan area? See *Bellevue Hospital Center* v. *Leavitt*, 443 F. 3d 163, 174–176 (CA2 2006).
- Congress directed the Department of the Interior and the Federal Aviation Administration to reduce noise from aircraft flying over Grand Canyon National Park—specifically, to "provide for substantial restoration of the natural quiet." §3(b)(1), 101 Stat. 676; see §3(b)(2). How much noise is consistent with "the natural quiet"? And how much of the park, for how many hours a day, must be that quiet for the "substantial restoration" requirement to be met? See *Grand Canyon Air Tour Coalition* v. *FAA*, 154 F. 3d 455, 466–467, 474–475 (CADC 1998).
- Or take *Chevron* itself. In amendments to the Clean Air Act, Congress told States to require permits for modifying or constructing "stationary sources" of air pollution. 42 U. S. C. §7502(c)(5). Does the term "stationary source[]" refer to each pollution-emitting piece of equipment within a plant? Or does it refer to the entire plant, and thus allow escape from the permitting requirement when increased emissions from one piece of equipment are offset by reductions from another? See 467 U. S., at 857, 859.

In each case, a statutory phrase has more than one reasonable reading. And Congress has not chosen among them: It has not, in any real-world sense, "fixed" the "single, best meaning" at "the time of enactment" (to use the majority's phrase). *Ante*, at 22. A question thus arises: Who decides which of the possible readings should govern?

This Court has long thought that the choice should usually fall to agencies, with courts broadly deferring to their judgments. For the last 40 years, that doctrine has gone by the name of *Chevron* deference, after the 1984 decision that formalized and canonized it. In *Chevron*, the Court set out a simple two-part framework for reviewing an agency's interpretation of a statute that it administers. First, the reviewing court must determine whether Congress has "directly spoken to the precise question at issue." 467 U. S., at 842. That inquiry is rigorous: A court must exhaust all the "traditional tools of statutory construction" to divine statutory meaning. *Id.*, at 843, n. 9. And when it can find that meaning—a "single right answer"—that is "the end of the matter": The court cannot defer because it "must give effect to the unambiguously expressed intent of Congress." *Kisor*, 588 U. S., at 575 (opinion of the Court); *Chevron*, 467 U. S., at 842–843. But if the court, after using its whole legal toolkit, concludes that "the statute is silent or ambiguous with respect to the specific issue" in dispute—for any of the not-uncommon reasons discussed above—then the court must cede the primary interpretive role. *Ibid.*; see *supra*, at 4–5. At that second step, the court asks only whether the agency construction is within the sphere of "reasonable" readings. *Chevron*, 467 U. S., at 844. If it is, the agency's interpretation of the statute that it every day implements will control.

That rule, the Court has long explained, rests on a presumption about legislative intent—about what Congress wants when a statute it has charged an agency with implementing contains an ambiguity or a gap. See *id.*, at 843–

845; *Smiley*, 517 U. S., at 740–741. An enacting Congress, as noted above, knows those uncertainties will arise, even if it does not know what they will turn out to be. See *supra*, at 4–5. And every once in a while, Congress provides an explicit instruction for dealing with that contingency—assigning primary responsibility to the courts, or else to an agency. But much more often, Congress does not say. Thus arises the need for a presumption—really, a default rule—for what should happen in that event. Does a statutory silence or ambiguity then go to a court for resolution? Or to an agency? This Court has long thought Congress would choose an agency, with courts serving only as a backstop to make sure the agency makes a reasonable choice among the possible readings. Or said otherwise, Congress would select the agency it has put in control of a regulatory scheme to exercise the "degree of discretion" that the statute's lack of clarity or completeness allows. *Smiley*, 517 U. S., at 741. Of course, Congress can always refute that presumptive choice—can say that, really, it would prefer courts to wield that discretionary power. But until then, the presumption cuts in the agency's favor.[1] The next question is why.

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[1] Note that presumptions of this kind are common in the law. In other contexts, too, the Court responds to a congressional lack of direction by adopting a presumption about what Congress wants, rather than trying to figure that out in every case. And then Congress can legislate, with "predictable effects," against that "stable background" rule. *Morrison* v. *National Australia Bank Ltd.*, 561 U. S. 247, 261 (2010). Take the presumption against extraterritoriality: The Court assumes Congress means for its statutes to apply only within the United States, absent a "clear indication" to the contrary. *Id.*, at 255. Or the presumption against retroactivity: The Court assumes Congress wants its laws to apply only prospectively, unless it "unambiguously instruct[s]" something different. *Vartelas* v. *Holder*, 566 U. S. 257, 266 (2012). Or the presumption against repeal of statutes by implication: The Court assumes Congress does not intend a later statute to displace an earlier one unless it makes that intention "clear and manifest." *Epic Systems Corp.* v. *Lewis*, 584 U. S. 497, 510 (2018). Or the (so far unnamed) presumption against treating a procedural requirement as "jurisdictional" unless "Congress

For one, because agencies often know things about a statute's subject matter that courts could not hope to. The point is especially stark when the statute is of a "scientific or technical nature." *Kisor*, 588 U. S., at 571 (plurality opinion). Agencies are staffed with "experts in the field" who can bring their training and knowledge to bear on open statutory questions. *Chevron*, 467 U. S., at 865. Consider, for example, the first bulleted case above. When does an alpha amino acid polymer qualify as a "protein"? See *supra*, at 5. I don't know many judges who would feel confident resolving that issue. (First question: What even *is* an alpha amino acid polymer?) But the FDA likely has scores of scientists on staff who can think intelligently about it, maybe collaborate with each other on its finer points, and arrive at a sensible answer. Or take the perhaps more accessible-sounding second case, involving the Endangered Species Act. See *supra*, at 5–6. Deciding when one squirrel population is "distinct" from another (and thus warrants protection) requires knowing about species more than it does consulting a dictionary. How much variation of what kind—geographic, genetic, morphological, or behavioral—should be required? A court could, if forced to, muddle through that issue and announce a result. But wouldn't the Fish and Wildlife Service, with all its specialized expertise, do a better job of the task—of saying what, in the context of species protection, the open-ended term "distinct" means? One idea behind the *Chevron* presumption is that Congress—

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clearly states that it is." *Boechler* v. *Commissioner*, 596 U. S. 199, 203 (2022). I could continue, except that this footnote is long enough. The *Chevron* deference rule is to the same effect: The Court generally assumes that Congress intends to confer discretion on agencies to handle statutory ambiguities or gaps, absent a direction to the contrary. The majority calls that presumption a "fiction," *ante*, at 26, but it is no more so than any of the presumptions listed above. They all are best guesses—and usually quite good guesses—by courts about congressional intent.

the same Congress that charged the Service with implementing the Act—would answer that question with a resounding "yes."

A second idea is that Congress would value the agency's experience with how a complex regulatory regime functions, and with what is needed to make it effective. Let's stick with squirrels for a moment, except broaden the lens. In construing a term like "distinct" in a case about squirrels, the Service likely would benefit from its "historical familiarity" with how the term has covered the population segments of other species. *Martin* v. *Occupational Safety and Health Review Comm'n*, 499 U. S. 144, 153 (1991); see, *e.g.*, *Center for Biological Diversity* v. *Zinke*, 900 F. 3d 1053, 1060–1062 (CA9 2018) (arctic grayling); *Center for Biological Diversity* v. *Zinke*, 868 F. 3d 1054, 1056 (CA9 2017) (desert eagle). Just as a common-law court makes better decisions as it sees multiple variations on a theme, an agency's construction of a statutory term benefits from its unique exposure to all the related ways the term comes into play. Or consider, for another way regulatory familiarity matters, the example about adjusting Medicare reimbursement for geographic wage differences. See *supra*, at 6. According to a dictionary, the term "geographic area" could be as large as a multi-state region or as small as a census tract. How to choose? It would make sense to gather hard information about what reimbursement levels each approach will produce, to explore the ease of administering each on a nationwide basis, to survey how regulators have dealt with similar questions in the past, and to confer with the hospitals themselves about what makes sense. See *Kisor*, 588 U. S., at 571 (plurality opinion) (noting that agencies are able to "conduct factual investigations" and "consult with affected parties"). Congress knows the Department of Health and Human Services can do all those things—and that courts cannot.

Still more, *Chevron*'s presumption reflects that resolving

statutory ambiguities, as Congress well knows, is "often more a question of policy than of law." *Pauley* v. *BethEnergy Mines, Inc.*, 501 U. S. 680, 696 (1991). The task is less one of construing a text than of balancing competing goals and values. Consider the statutory directive to achieve "substantial restoration of the [Grand Canyon's] natural quiet." See *supra*, at 6. Someone is going to have to decide exactly what that statute means for air traffic over the canyon. How many flights, in what places and at what times, are consistent with restoring enough natural quiet on the ground? That is a policy trade-off of a kind familiar to agencies—but peculiarly unsuited to judges. Or consider *Chevron* itself. As the Court there understood, the choice between defining a "stationary source" as a whole plant or as a pollution-emitting device is a choice about how to "reconcile" two "manifestly competing interests." 467 U. S., at 865. The plantwide definition relaxes the permitting requirement in the interest of promoting economic growth; the device-specific definition strengthens that requirement to better reduce air pollution. See *id.*, at 851, 863, 866. Again, that is a choice a judge should not be making, but one an agency properly can. Agencies are "subject to the supervision of the President, who in turn answers to the public." *Kisor*, 588 U. S., at 571–572 (plurality opinion). So when faced with a statutory ambiguity, "an agency to which Congress has delegated policymaking responsibilities" may rely on an accountable actor's "views of wise policy to inform its judgments." *Chevron*, 467 U. S., at 865.

None of this is to say that deference to agencies is always appropriate. The Court over time has fine-tuned the *Chevron* regime to deny deference in classes of cases in which Congress has no reason to prefer an agency to a court. The majority treats those "refinements" as a flaw in the scheme, *ante*, at 27, but they are anything but. Consider the rule that an agency gets no deference when construing a statute it is not responsible for administering. See *Epic Systems*

Corp. v. *Lewis*, 584 U. S. 497, 519–520 (2018). Well, of course not—if Congress has not put an agency in charge of implementing a statute, Congress would not have given the agency a special role in its construction. Or take the rule that an agency will not receive deference if it has reached its decision without using—or without using properly—its rulemaking or adjudicatory authority. See *United States* v. *Mead Corp.*, 533 U. S. 218, 226–227 (2001); *Encino Motorcars, LLC* v. *Navarro*, 579 U. S. 211, 220 (2016). Again, that should not be surprising: Congress expects that authoritative pronouncements on a law's meaning will come from the procedures it has enacted to foster "fairness and deliberation" in agency decision-making. *Mead*, 533 U. S., at 230. Or finally, think of the "extraordinary cases" involving questions of vast "economic and political significance" in which the Court has declined to defer. *King* v. *Burwell*, 576 U. S. 473, 485–486 (2015). The theory is that Congress would not have left matters of such import to an agency, but would instead have insisted on maintaining control. So the *Chevron* refinements proceed from the same place as the original doctrine. Taken together, they give interpretive primacy to the agency when—but only when—it is acting, as Congress specified, in the heartland of its delegated authority.

That carefully calibrated framework "reflects a sensitivity to the proper roles of the political and judicial branches." *Pauley*, 501 U. S., at 696. Where Congress has spoken, Congress has spoken; only its judgments matter. And courts alone determine when that has happened: Using all their normal interpretive tools, they decide whether Congress has addressed a given issue. But when courts have decided that Congress has not done so, a choice arises. Absent a legislative directive, either the administering agency or a court must take the lead. And the matter is more fit for the agency. The decision is likely to involve the agency's subject-matter expertise; to fall within its sphere of regulatory

experience; and to involve policy choices, including cost-benefit assessments and trade-offs between conflicting values. So a court without relevant expertise or experience, and without warrant to make policy calls, appropriately steps back. The court still has a role to play: It polices the agency to ensure that it acts within the zone of reasonable options. But the court does not insert itself into an agency's expertise-driven, policy-laden functions. That is the arrangement best suited to keep every actor in its proper lane. And it is the one best suited to ensure that Congress's statutes work in the way Congress intended.

The majority makes two points in reply, neither convincing. First, it insists that "agencies have no special competence" in filling gaps or resolving ambiguities in regulatory statutes; rather, "[c]ourts do." *Ante*, at 23. Score one for self-confidence; maybe not so high for self-reflection or -knowledge. Of course courts often construe legal texts, hopefully well. And *Chevron*'s first step takes full advantage of that talent: There, a court tries to divine what Congress meant, even in the most complicated or abstruse statutory schemes. The deference comes in only if the court cannot do so—if the court must admit that standard legal tools will not avail to fill a statutory silence or give content to an ambiguous term. That is when the issues look like the ones I started off with: When does an alpha amino acid polymer qualify as a "protein"? How distinct is "distinct" for squirrel populations? What size "geographic area" will ensure appropriate hospital reimbursement? As between two equally feasible understandings of "stationary source," should one choose the one more protective of the environment or the one more favorable to economic growth? The idea that courts have "special competence" in deciding such questions whereas agencies have "no[ne]" is, if I may say, malarkey. Answering those questions right does not mainly demand the interpretive skills courts possess. Instead, it demands one or more of: subject-matter expertise,

long engagement with a regulatory scheme, and policy choice. It is courts (not agencies) that "have no special competence"—or even legitimacy—when those are the things a decision calls for.

Second, the majority complains that an ambiguity or gap does not "necessarily reflect a congressional intent that an agency" should have primary interpretive authority. *Ante*, at 22. On that score, I'll agree with the premise: It doesn't "necessarily" do so. *Chevron* is built on a *presumption*. The decision does not maintain that Congress in every case wants the agency, rather than a court, to fill in gaps. The decision maintains that when Congress does not expressly pick one or the other, we need a default rule; and the best default rule—agency or court?—is the one we think Congress would generally want. As to *why* Congress would generally want the agency: The answer lies in everything said above about Congress's delegation of regulatory power to the agency and the agency's special competencies. See *supra*, at 9–11. The majority appears to think it is a showstopping rejoinder to note that many statutory gaps and ambiguities are "unintentional." *Ante*, at 22. But to begin, many are not; the ratio between the two is uncertain. See *supra*, at 4–5. And to end, why should that matter in any event? Congress may not have deliberately introduced a gap or ambiguity into the statute; but it knows that pretty much everything it drafts will someday be found to contain such a "flaw." Given that knowledge, *Chevron* asks, what would Congress want? The presumed answer is again the same (for the same reasons): The agency. And as with any default rule, if Congress decides otherwise, all it need do is say.

In that respect, the proof really is in the pudding: Congress basically never says otherwise, suggesting that *Chevron* chose the presumption aligning with legislative intent (or, in the majority's words, "approximat[ing] reality," *ante*, at 22). Over the last four decades, Congress has authorized

or reauthorized hundreds of statutes. The drafters of those statutes knew all about *Chevron*. See A. Gluck & L. Bressman, Statutory Interpretation From the Inside—An Empirical Study of Congressional Drafting, Delegation, and the Canons: Part I, 65 Stan. L. Rev. 901, 928 (fig. 2), 994 (2013). So if they had wanted a different assignment of interpretive responsibility, they would have inserted a provision to that effect. With just a pair of exceptions I know of, they did not. See 12 U. S. C. §25b(b)(5)(A) (exception #1); 15 U. S. C. §8302(c)(3)(A) (exception #2). Similarly, Congress has declined to enact proposed legislation that would abolish *Chevron* across the board. See S. 909, 116th Cong., 1st Sess., §2 (2019) (still a bill, not a law); H. R. 5, 115th Cong., 1st Sess., §202 (2017) (same). So to the extent the majority is worried that the *Chevron* presumption is "fiction[al]," *ante*, at 26—as all legal presumptions in some sense are—it has gotten less and less so every day for 40 years. The congressional reaction shows as well as anything could that the *Chevron* Court read Congress right.

II

The majority's principal arguments are in a different vein. Around 80 years after the APA was enacted and 40 years after *Chevron*, the majority has decided that the former precludes the latter. The APA's Section 706, the majority says, "makes clear" that agency interpretations of statutes "are *not* entitled to deference." *Ante*, at 14–15 (emphasis in original). And that provision, the majority continues, codified the contemporaneous law, which likewise did not allow for deference. See *ante,* at 9–13, 15–16. But neither the APA nor the pre-APA state of the law does the work that the majority claims. Both are perfectly compatible with *Chevron* deference.

Section 706, enacted with the rest of the APA in 1946, provides for judicial review of agency action. It states: "To the extent necessary to decision and when presented, the

reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action." 5 U. S. C. §706.

That text, contra the majority, "does not resolve the *Chevron* question." C. Sunstein, *Chevron* As Law, 107 Geo. L. J. 1613, 1642 (2019) (Sunstein). Or said a bit differently, Section 706 is "generally indeterminate" on the matter of deference. A. Vermeule, Judging Under Uncertainty 207 (2006) (Vermeule). The majority highlights the phrase "decide all relevant questions of law" (italicizing the "all"), and notes that the provision "prescribes no deferential standard" for answering those questions. *Ante*, at 14. But just as the provision does not prescribe a deferential standard of review, so too it does not prescribe a *de novo* standard of review (in which the court starts from scratch, without giving deference). In point of fact, Section 706 does not specify *any* standard of review for construing statutes. See *Kisor*, 588 U. S., at 581 (plurality opinion). And when a court uses a deferential standard—here, by deciding whether an agency reading is reasonable—it just as much "decide[s]" a "relevant question[] of law" as when it uses a *de novo* standard. §706. The deferring court then conforms to Section 706 "by determining whether the agency has stayed within the bounds of its assigned discretion—that is, whether the agency has construed [the statute it administers] reasonably." J. Manning, *Chevron* and the Reasonable Legislator, 128 Harv. L. Rev. 457, 459 (2014); see *Arlington* v. *FCC*, 569 U. S. 290, 317 (2013) (ROBERTS, C. J., dissenting) ("We do not ignore [Section 706's] command when we afford an agency's statutory interpretation *Chevron* deference; we respect it").[2]

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[2]The majority tries to buttress its argument with a stray sentence or two from the APA's legislative history, but the same response holds. As the majority notes, see *ante*, at 15, the House and Senate Reports each stated that Section 706 "provid[ed] that questions of law are for courts

Section 706's references to standards of review in other contexts only further undercut the majority's argument. The majority notes that Section 706 requires deferential review for agency fact-finding and policy-making (under, respectively, a substantial-evidence standard and an arbitrary-and-capricious standard). See *ante*, at 14. Congress, the majority claims, "surely would have articulated a similarly deferential standard applicable to questions of law had it intended to depart" from *de novo* review. *Ibid.* Surely? In another part of Section 706, Congress explicitly referred to *de novo* review. §706(2)(F). With all those references to standards of review—both deferential and not—running around Section 706, what is "telling" (*ante*, at 14) is the absence of any standard for reviewing an agency's statutory constructions. That silence left the matter, as noted above, "generally indeterminate": Section 706 neither mandates nor forbids *Chevron*-style deference. Vermeule 207.[3]

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rather than agencies to decide in the last analysis." H. R. Rep. No. 1980, 79th Cong., 2d Sess., 44 (1946); S. Rep. No. 752, 79th Cong., 1st Sess., 28 (1945). But that statement also does not address the standard of review that courts should then use. When a court defers under *Chevron*, it reviews the agency's construction for reasonableness "in the last analysis." The views of Representative Walter, which the majority also cites, further demonstrate my point. He stated that the APA would require courts to "determine independently all relevant questions of law," but he also stated that courts would be required to "exercise . . . independent judgment" in applying the substantial-evidence standard (a deferential standard if ever there were one). 92 Cong. Rec. 5654 (1946). He therefore did not equate "independent" review with *de novo* review; he thought that a court could conduct independent review of agency action using a deferential standard.

[3] In a footnote responding to the last two paragraphs, the majority raises the white flag on Section 706's text. See *ante*, at 15, n. 4. Yes, it finally concedes, Section 706 does not *say* that *de novo* review is required for an agency's statutory construction. Rather, the majority says, "some things go without saying," and *de novo* review is such a thing. See *ibid.* But why? What extra-textual considerations force us to read Section 706 the majority's way? In its footnote, the majority repairs only to history.

And contra the majority, most "respected commentators" understood Section 706 in that way—as allowing, even if not requiring, deference. *Ante*, at 16. The finest administrative law scholars of the time (call them that generation's Manning, Sunstein, and Vermeule) certainly did. Professor Louis Jaffe described something very like the *Chevron* two-step as the preferred method of reviewing agency interpretations under the APA. A court, he said, first "must decide as a 'question of law' whether there is 'discretion' in the premises." Judicial Control of Administrative Action 570 (1965). That is akin to step 1: Did Congress speak to the issue, or did it leave openness? And if the latter, Jaffe continued, the agency's view "if 'reasonable' is free of control." *Ibid.* That of course looks like step 2: defer if reasonable. And just in case that description was too complicated, Jaffe conveyed his main point this way: The argument that courts "must decide all questions of law"—as if there were no agency in the picture—"is, in my opinion, unsound." *Id.*, at 569. Similarly, Professor Kenneth Culp Davis, author of the then-preeminent treatise on administrative law, noted with approval that "reasonableness" review of agency interpretations—in which courts "refused to substitute judgment"—had "survived the APA." Administrative Law 880, 883, 885 (1951) (Davis). Other contemporaneous scholars and experts agreed. See R. Levin, The APA and the Assault on Deference, 106 Minn. L. Rev. 125, 181–183 (2021) (Levin) (listing many of them). They did not see in their own time what the majority finds there today.[4]

But as I will explain below, the majority also gets wrong the most relevant history, pertaining to how judicial review of agency interpretations operated in the years before the APA was enacted. See *infra*, at 19–23.

[4] I concede one exception (whose view was "almost completely isolated," Levin 181), but his comments on Section 706 refute a different aspect of the majority's argument. Professor John Dickinson, as the majority notes, thought that Section 706 precluded courts from deferring to agency interpretations. See Administrative Procedure Act: Scope and Grounds of Broadened Judicial Review, 33 A. B. A. J. 434, 516 (1947)

Nor, evidently, did the Supreme Court. In the years after the APA was enacted, the Court "never indicated that section 706 rejected the idea that courts might defer to agency interpretations of law." Sunstein 1654. Indeed, not a single Justice so much as floated that view of the APA. To the contrary, the Court issued a number of decisions in those years deferring to an agency's statutory interpretation. See, *e.g.*, *Unemployment Compensation Comm'n of Alaska* v. *Aragon*, 329 U. S. 143, 153–154 (1946); *NLRB* v. *E. C. Atkins & Co.*, 331 U. S. 398, 403 (1947); *Cardillo* v. *Liberty Mut. Ins. Co.*, 330 U. S. 469, 478–479 (1947). And that continued right up until *Chevron*. See, *e.g.*, *Mitchell* v. *Budd*, 350 U. S. 473, 480 (1956); *Zenith Radio Corp.* v. *United States*, 437 U. S. 443, 450 (1978). To be clear: Deference in those years was not always given to interpretations that would receive it under *Chevron*. The practice then was more inconsistent and less fully elaborated than it later became. The point here is only that the Court came nowhere close to accepting the majority's view of the APA. Take the language from Section 706 that the majority most relies on: "decide all relevant questions of law." See *ante*, at 14. In the decade after the APA's enactment, those words were used only four times in Supreme Court opinions (all in footnotes)—and never to suggest that courts could not defer to agency interpretations. See Sunstein 1656.

The majority's view of Section 706 likewise gets no support from how judicial review operated in the years leading up to the APA. That prior history matters: As the majority recognizes, Section 706 was generally understood to "restate[] the present law as to the scope of judicial review."

(Dickinson); *ante*, at 16. But unlike the majority, he viewed that bar as "a change" to, not a restatement of, pre-APA law. Compare Dickinson 516 with *ante*, at 15–16. So if the majority really wants to rely on Professor Dickinson, it will have to give up the claim, which I address below, that the law before the APA forbade deference. See *infra*, at 19–23.

Dept. of Justice, Attorney General's Manual on the Administrative Procedure Act 108 (1947); *ante*, at 15–16. The problem for the majority is that in the years preceding the APA, courts became ever more deferential to agencies. New Deal administrative programs had by that point come into their own. And this Court and others, in a fairly short time, had abandoned their initial resistance and gotten on board. Justice Breyer, wearing his administrative-law-scholar hat, characterized the pre-APA period this way: "[J]udicial review of administrative action was curtailed, and particular agency decisions were frequently sustained with judicial obeisance to the mysteries of administrative expertise." S. Breyer et al., Administrative Law and Regulatory Policy 21 (7th ed. 2011). And that description extends to review of an agency's statutory constructions. An influential study of administrative practice, published five years before the APA's enactment, described the state of play: Judicial "review may, in some instances at least, be limited to the inquiry whether the administrative construction is a permissible one." Final Report of Attorney General's Committee on Administrative Procedure (1941), reprinted in Administrative Procedure in Government Agencies, S. Doc. No. 8, 77th Cong., 1st Sess., 78 (1941). Or again: "[W]here the statute is reasonably susceptible of more than one interpretation, the court may accept that of the administrative body." *Id.*, at 90–91.[5]

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[5] Because the APA was meant to "restate[] the present law," the judicial review practices of the 1940s are more important to understanding the statute than is any earlier tradition (such as the majority dwells on). But before I expand on those APA-contemporaneous practices, I pause to note that they were "not built on sand." *Kisor* v. *Wilkie*, 588 U. S. 558, 568–569 (2019) (plurality opinion). Since the early days of the Republic, this Court has given significant weight to official interpretations of "ambiguous law[s]." *Edwards' Lessee* v. *Darby*, 12 Wheat. 206, 210 (1827). With the passage of time—and the growth of the administrative sphere—those "judicial expressions of deference increased." H. Monaghan, *Marbury* and the Administrative State, 83 Colum. L. Rev. 1, 15 (1983). By

Two prominent Supreme Court decisions of the 1940s put those principles into action. *Gray* v. *Powell*, 314 U. S. 402 (1941), was then widely understood as "the leading case" on review of agency interpretations. Davis 882; see *ibid.* (noting that it "establish[ed] what is known as 'the doctrine of Gray v. Powell'"). There, the Court deferred to an agency construction of the term "producer" as used in a statutory exemption from price controls. Congress, the Court explained, had committed the scope of the exemption to the agency because its "experience in [the] field gave promise of a better informed, more equitable, adjustment of the conflicting interests." *Gray*, 314 U. S., at 412. Accordingly, the Court concluded that it was "not the province of a court" to "substitute its judgment" for the agency's. *Ibid.* Three years later, the Court decided *NLRB* v. *Hearst Publications, Inc.*, 322 U. S. 111 (1944), another acknowledged "leading case." Davis 882; see *id.*, at 884. The Court again deferred, this time to an agency's construction of the term "employee" in the National Labor Relations Act. The scope of that term, the Court explained, "belong[ed] to" the agency to answer based on its "[e]veryday experience in the administration of the statute." *Hearst*, 322 U. S., at 130. The Court therefore "limited" its review to whether the agency's reading had "warrant in the record and a reasonable basis in

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the early 20th century, the Court stated that it would afford "great weight" to an agency construction in the face of statutory "uncertainty or ambiguity." *National Lead Co.* v. *United States*, 252 U. S. 140, 145 (1920); see *Schell's Executors* v. *Fauché*, 138 U. S. 562, 572 (1891) ("controlling" weight in "all cases of ambiguity"); *United States* v. *Alabama Great Southern R. Co.*, 142 U. S. 615, 621 (1892) ("decisive" weight "in case of ambiguity"); *Jacobs* v. *Prichard*, 223 U. S. 200, 214 (1912) (referring to the "rule which gives strength" to official interpretations if "ambiguity exist[s]"). So even before the New Deal, a strand of this Court's cases exemplified deference to executive constructions of ambiguous statutes. And then, as I show in the text, the New Deal arrived and deference surged—creating the "present law" that the APA "restated."

law." *Id.*, at 131.[6] Recall here that even the majority accepts that Section 706 was meant to "restate[] the present law" as to judicial review. See *ante*, at 15–16; *supra*, at 19–20. Well then? It sure would seem that the provision allows a deference regime.

The majority has no way around those two noteworthy decisions. It first appears to distinguish between "pure legal question[s]" and the so-called mixed questions in *Gray* and *Hearst*, involving the application of a legal standard to a set of facts. *Ante*, at 11. If in drawing that distinction, the majority intends to confine its holding to the pure type of legal issue—thus enabling courts to defer when law and facts are entwined—I'd be glad. But I suspect the majority has no such intent, because that approach would preserve *Chevron* in a substantial part of its current domain. Cf. *Wilkinson* v. *Garland*, 601 U. S. 209, 230 (2024) (ALITO, J., dissenting) (noting, in the immigration context, that the universe of mixed questions swamps that of pure legal ones). It is frequently in the consideration of mixed questions that the scope of statutory terms is established and their meaning defined. See H. Monaghan, *Marbury* and the

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[6]The majority says that I have "pluck[ed] out" *Gray* and *Hearst*, impliedly from a vast number of not-so-helpful cases. *Ante*, at 13, n. 3. It would make as much sense to say that a judge "plucked out" *Universal Camera Corp.* v. *NLRB*, 340 U. S. 474 (1951), to discuss substantial-evidence review or "plucked out" *Motor Vehicle Mfrs. Assn. of United States, Inc.* v. *State Farm Mut. Automobile Ins. Co.*, 463 U. S. 29 (1983), to discuss arbitrary-and-capricious review. *Gray* and *Hearst*, as noted above, were the leading cases about agency interpretations in the years before the APA's enactment. But just to gild the lily, here are a number of other Supreme Court decisions from the five years prior to the APA's enactment that were of a piece: *United States* v. *Pierce Auto Freight Lines, Inc.*, 327 U. S. 515, 536 (1946); *ICC* v. *Parker*, 326 U. S. 60, 65 (1945); *Federal Security Administrator* v. *Quaker Oats Co.*, 318 U. S. 218, 227–228 (1943). The real "pluck[ing]" offense is the majority's—for taking a stray sentence from *Hearst* (*ante*, at 13, n. 3) to suggest that both *Hearst* and *Gray* stand for the opposite of what they actually do.

Administrative State, 83 Colum. L. Rev. 1, 29 (1983) ("Administrative application of law is administrative formulation of law whenever it involves elaboration of the statutory norm"). How does a statutory interpreter decide, as in *Hearst*, what an "employee" is? In large part through cases asking whether the term covers people performing specific jobs, like (in that case) "newsboys." 322 U. S., at 120. Or consider one of the examples I offered above. How does an interpreter decide when one population segment of a species is "distinct" from another? Often by considering that requirement with respect to particular species, like western gray squirrels. So the distinction the majority offers makes no real-world (or even theoretical) sense. If the *Hearst* Court was deferring to an agency on whether the term "employee" covered newsboys, it was deferring to the agency on the scope and meaning of the term "employee."

The majority's next rejoinder—that "the Court was far from consistent" in deferring—falls equally flat. *Ante*, at 12. I am perfectly ready to acknowledge that in the pre-APA period, a deference regime had not yet taken complete hold. I'll go even further: Let's assume that deference was then an on-again, off-again function (as the majority seems to suggest, see *ante*, at 11–12, and 13, n. 3). Even on that assumption, the majority's main argument—that Section 706 *prohibited* deferential review—collapses. Once again, the majority agrees that Section 706 was not meant to change the then-prevailing law. See *ante*, at 15–16. And even if inconsistent, that law cannot possibly be thought to have *prohibited* deference. Or otherwise said: "If Section 706 did not change the law of judicial review (as we have long recognized), then it did not proscribe a deferential standard then known and in use." *Kisor*, 588 U. S., at 583 (plurality opinion).

The majority's whole argument for overturning *Chevron* relies on Section 706. But the text of Section 706 does not support that result. And neither does the contemporaneous

practice, which that text was supposed to reflect. So today's decision has no basis in the only law the majority deems relevant. It is grounded on air.

III

And still there is worse, because abandoning *Chevron* subverts every known principle of *stare decisis*. Of course, respecting precedent is not an "inexorable command." *Payne* v. *Tennessee*, 501 U. S. 808, 828 (1991). But overthrowing it requires far more than the majority has offered up here. *Chevron* is entitled to *stare decisis*'s strongest form of protection. The majority thus needs an exceptionally strong reason to overturn the decision, above and beyond thinking it wrong. And it has nothing approaching such a justification, proposing only a bewildering theory about *Chevron*'s "unworkability." *Ante*, at 32. Just five years ago, this Court in *Kisor* rejected a plea to overrule *Auer* v. *Robbins*, 519 U. S. 452 (1997), which requires judicial deference to agencies' interpretations of their own regulations. See 588 U. S., at 586–589 (opinion of the Court). The case against overruling *Chevron* is at least as strong. In particular, the majority's decision today will cause a massive shock to the legal system, "cast[ing] doubt on many settled constructions" of statutes and threatening the interests of many parties who have relied on them for years. 588 U. S., at 587 (opinion of the Court).

Adherence to precedent is "a foundation stone of the rule of law." *Michigan* v. *Bay Mills Indian Community*, 572 U. S. 782, 798 (2014). *Stare decisis* "promotes the evenhanded, predictable, and consistent development of legal principles." *Payne*, 501 U. S., at 827. It enables people to order their lives in reliance on judicial decisions. And it "contributes to the actual and perceived integrity of the judicial process," by ensuring that those decisions are founded in the law, and not in the "personal preferences" of judges. *Id.*, at 828; *Dobbs*, 597 U. S., at 388 (dissenting opinion).

Perhaps above all else, *stare decisis* is a "doctrine of judicial modesty." *Id.*, at 363. In that, it shares something important with *Chevron*. Both tell judges that they do not know everything, and would do well to attend to the views of others. So today, the majority rejects what judicial humility counsels not just once but twice over.

And *Chevron* is entitled to a particularly strong form of *stare decisis*, for two separate reasons. First, it matters that "Congress remains free to alter what we have done." *Patterson* v. *McLean Credit Union*, 491 U. S. 164, 173 (1989); see *Kisor*, 588 U. S., at 587 (opinion of the Court) (making the same point for *Auer* deference). In a constitutional case, the Court alone can correct an error. But that is not so here. "Our deference decisions are balls tossed into Congress's court, for acceptance or not as that branch elects." 588 U. S., at 587–588 (opinion of the Court). And for generations now, Congress has chosen acceptance. Throughout those years, Congress could have abolished *Chevron* across the board, most easily by amending the APA. Or it could have eliminated deferential review in discrete areas, by amending old laws or drafting new laws to include an anti-*Chevron* provision. Instead, Congress has "spurned multiple opportunities" to do a comprehensive rejection of *Chevron*, and has hardly ever done a targeted one. *Kimble* v. *Marvel Entertainment, LLC*, 576 U. S. 446, 456 (2015); see *supra*, at 14–15. Or to put the point more affirmatively, Congress has kept *Chevron* as is for 40 years. It maintained that position even as Members of this Court began to call *Chevron* into question. See *ante*, at 30. From all it appears, Congress has not agreed with the view of some Justices that they and other judges should have more power.

Second, *Chevron* is by now much more than a single decision. This Court alone, acting as *Chevron* allows, has upheld an agency's reasonable interpretation of a statute at least 70 times. See Brief for United States in No. 22–1219,

p. 27; App. to *id.*, at 68a–72a (collecting cases). Lower courts have applied the *Chevron* framework on thousands upon thousands of occasions. See K. Barnett & C. Walker, *Chevron* and Stare Decisis, 31 Geo. Mason L. Rev. 475, 477, and n. 11 (2024) (noting that at last count, *Chevron* was cited in more than 18,000 federal-court decisions). The *Kisor* Court observed, when upholding *Auer*, that "[d]eference to reasonable agency interpretations of ambiguous rules pervades the whole corpus of administrative law." 588 U. S., at 587 (opinion of the Court). So too does deference to reasonable agency interpretations of ambiguous statutes—except more so. *Chevron* is as embedded as embedded gets in the law.

The majority says differently, because this Court has ignored *Chevron* lately; all that is left of the decision is a "decaying husk with bold pretensions." *Ante*, at 33. Tell that to the D. C. Circuit, the court that reviews a large share of agency interpretations, where *Chevron* remains alive and well. See, *e.g.*, *Lissack* v. *Commissioner*, 68 F. 4th 1312, 1321–1322 (2023); *Solar Energy Industries Assn.* v. *FERC*, 59 F. 4th 1287, 1291–1294 (2023). But more to the point: The majority's argument is a bootstrap. This Court has "avoided deferring under *Chevron* since 2016" (*ante*, at 32) because it has been preparing to overrule *Chevron* since around that time. That kind of self-help on the way to reversing precedent has become almost routine at this Court. Stop applying a decision where one should; "throw some gratuitous criticisms into a couple of opinions"; issue a few separate writings "question[ing the decision's] premises" (*ante*, at 30); give the whole process a few years . . . and voila!—you have a justification for overruling the decision. *Janus* v. *State, County, and Municipal Employees*, 585 U. S. 878, 950 (2018) (KAGAN, J., dissenting) (discussing the overruling of *Abood* v. *Detroit Bd. of Ed.*, 431 U. S. 209 (1977)); see also, *e.g.*, *Kennedy* v. *Bremerton School Dist.*, 597 U. S. 507, 571–572 (2022) (SOTOMAYOR, J., dissenting) (similar

for *Lemon* v. *Kurtzman*, 403 U. S. 602 (1971)); *Shelby County* v. *Holder*, 570 U. S. 529, 587–588 (2013) (Ginsburg, J., dissenting) (similar for *South Carolina* v. *Katzenbach*, 383 U. S. 301 (1966)). I once remarked that this overruling-through-enfeeblement technique "mock[ed] *stare decisis*." *Janus*, 585 U. S., at 950 (dissenting opinion). I have seen no reason to change my mind.

The majority does no better in its main justification for overruling *Chevron*—that the decision is "unworkable." *Ante*, at 30. The majority's first theory on that score is that there is no single "answer" about what "ambiguity" means: Some judges turn out to see more of it than others do, leading to "different results." *Ante*, at 30–31. But even if so, the legal system has for many years, in many contexts, dealt perfectly well with that variation. Take contract law. It is hornbook stuff that when (but only when) a contract is ambiguous, a court interpreting it can consult extrinsic evidence. See *CNH Industrial N.V.* v. *Reese*, 583 U. S. 133, 139 (2018) (*per curiam*). And when all interpretive tools still leave ambiguity, the contract is construed against the drafter. See *Lamps Plus, Inc.* v. *Varela*, 587 U. S. 176, 186–187 (2019). So I guess the contract rules of the 50 States are unworkable now. Or look closer to home, to doctrines this Court regularly applies. In deciding whether a government has waived sovereign immunity, we construe "[a]ny ambiguities in the statutory language" in "favor of immunity." *FAA* v. *Cooper*, 566 U. S. 284, 290 (2012). Similarly, the rule of lenity tells us to construe ambiguous statutes in favor of criminal defendants. See *United States* v. *Castleman*, 572 U. S. 157, 172–173 (2014). And the canon of constitutional avoidance instructs us to construe ambiguous laws to avoid difficult constitutional questions. See *United States* v. *Oakland Cannabis Buyers' Cooperative*, 532 U. S. 483, 494 (2001). I could go on, but the point is made. There are ambiguity triggers all over the law. Somehow everyone seems to get by.

And *Chevron* is an especially puzzling decision to criticize on the ground of generating too much judicial divergence. There's good empirical—meaning, non-impressionistic—evidence on exactly that subject. And it shows that, as compared with *de novo* review, use of the *Chevron* two-step framework fosters *agreement* among judges. See K. Barnett, C. Boyd, & C. Walker, Administrative Law's Political Dynamics, 71 Vand. L. Rev. 1463, 1502 (2018) (Barnett). More particularly, *Chevron* has a "powerful constraining effect on partisanship in judicial decisionmaking." Barnett 1463 (italics deleted); see Sunstein 1672 ("[A] predictable effect of overruling *Chevron* would be to ensure a far greater role for judicial policy preferences in statutory interpretation and far more common splits along ideological lines"). So if consistency among judges is the majority's lodestar, then the Court should not overrule *Chevron*, but return to using it.

The majority's second theory on workability is likewise a makeweight. *Chevron*, the majority complains, has some exceptions, which (so the majority says) are "difficult" and "complicate[d]" to apply. *Ante*, at 32. Recall that courts are not supposed to defer when the agency construing a statute (1) has not been charged with administering that law; (2) has not used deliberative procedures—*i.e.,* notice-and-comment rulemaking or adjudication; or (3) is intervening in a "major question," of great economic and political significance. See *supra*, at 11–12; *ante*, at 27–28. As I've explained, those exceptions—the majority also aptly calls them "refinements"—fit with *Chevron*'s rationale: They define circumstances in which Congress is unlikely to have wanted agency views to govern. *Ante*, at 27; see *supra*, at 11–12. And on the difficulty scale, they are nothing much. Has Congress put the agency in charge of administering the statute? In 99 of 100 cases, everyone will agree on the answer with scarcely a moment's thought. Did the agency use notice-and-comment or an adjudication before rendering an

interpretation? Once again, I could stretch my mind and think up a few edge cases, but for the most part, the answer is an easy yes or no. The major questions exception is, I acknowledge, different: There, many judges have indeed disputed its nature and scope. Compare, *e.g.*, *West Virginia*, 597 U. S., at 721–724, with *id.*, at 764–770 (KAGAN, J., dissenting). But that disagreement concerns, on everyone's view, a tiny subset of all agency interpretations. For the most part, the exceptions that so upset the majority require merely a rote, check-the-box inquiry. If that is the majority's idea of a "dizzying breakdance," *ante*, at 32, the majority needs to get out more.

And anyway, difficult as compared to what? The majority's prescribed way of proceeding is no walk in the park. First, the majority makes clear that what is usually called *Skidmore* deference continues to apply. See *ante*, at 16–17. Under that decision, agency interpretations "constitute a body of experience and informed judgment" that may be "entitled to respect." *Skidmore* v. *Swift & Co.*, 323 U. S. 134, 140 (1944). If the majority thinks that the same judges who argue today about where "ambiguity" resides (see *ante*, at 30) are not going to argue tomorrow about what "respect" requires, I fear it will be gravely disappointed. Second, the majority directs courts to comply with the varied ways in which Congress in fact "delegates discretionary authority" to agencies. *Ante*, at 17–18. For example, Congress may authorize an agency to "define[]" or "delimit[]" statutory terms or concepts, or to "fill up the details" of a statutory scheme. *Ante*, at 17, and n. 5. Or Congress may use, in describing an agency's regulatory authority, inherently "flexib[le]" language like "appropriate" or "reasonable." *Ante*, at 17, and n. 6. Attending to every such delegation, as the majority says, is necessary in a world without *Chevron*. But that task involves complexities of its own. Indeed, one reason Justice Scalia supported *Chevron* was that it re-

placed such a "statute-by-statute evaluation (which was assuredly a font of uncertainty and litigation) with an across-the-board presumption." A. Scalia, Judicial Deference to Administrative Interpretations of Law, 1989 Duke L. J. 511, 516. As a lover of the predictability that rules create, Justice Scalia thought the latter "unquestionably better." *Id.*, at 517.

On the other side of the balance, the most important *stare decisis* factor—call it the "jolt to the legal system" issue—weighs heavily against overruling *Chevron*. *Dobbs*, 597 U. S., at 357 (ROBERTS, C. J., concurring in judgment). Congress and agencies alike have relied on *Chevron*—have assumed its existence—in much of their work for the last 40 years. Statutes passed during that time reflect the expectation that *Chevron* would allocate interpretive authority between agencies and courts. Rules issued during the period likewise presuppose that statutory ambiguities were the agencies' to (reasonably) resolve. Those agency interpretations may have benefited regulated entities; or they may have protected members of the broader public. Either way, private parties have ordered their affairs—their business and financial decisions, their health-care decisions, their educational decisions—around agency actions that are suddenly now subject to challenge. In *Kisor*, this Court refused to overrule *Auer* because doing so would "cast doubt on" many longstanding constructions of rules, and thereby upset settled expectations. 588 U. S., at 587 (opinion of the Court). Overruling *Chevron*, and thus raising new doubts about agency constructions of statutes, will be far more disruptive.

The majority tries to alleviate concerns about a piece of that problem: It states that judicial decisions that have upheld agency action as reasonable under *Chevron* should not be overruled on that account alone. See *ante*, at 34–35. That is all to the good: There are thousands of such decisions, many settled for decades. See *supra*, at 26. But first,

reasonable reliance need not be predicated on a prior judicial decision. Some agency interpretations never challenged under *Chevron* now will be; expectations formed around those constructions thus could be upset, in a way the majority's assurance does not touch. And anyway, how good is that assurance, really? The majority says that a decision's "[m]ere reliance on *Chevron*" is not enough to counter the force of *stare decisis*; a challenger will need an additional "special justification." *Ante*, at 34. The majority is sanguine; I am not so much. Courts motivated to overrule an old *Chevron*-based decision can always come up with something to label a "special justification." Maybe a court will say "the quality of [the precedent's] reasoning" was poor. *Ante*, at 29. Or maybe the court will discover something "unworkable" in the decision—like some exception that has to be applied. *Ante*, at 30. All a court need do is look to today's opinion to see how it is done.

IV

> Judges are not experts in the field, and are not part of either political branch of the Government.
>
> —*Chevron U. S. A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U. S. 837, 865 (1984)

Those were the days, when we knew what we are not. When we knew that as between courts and agencies, Congress would usually think agencies the better choice to resolve the ambiguities and fill the gaps in regulatory statutes. Because agencies *are* "experts in the field." And because they *are* part of a political branch, with a claim to making interstitial policy. And because Congress has charged them, not us, with administering the statutes containing the open questions. At its core, *Chevron* is about respecting that allocation of responsibility—the conferral of primary authority over regulatory matters to agencies, not courts.

Today, the majority does not respect that judgment. It gives courts the power to make all manner of scientific and technical judgments. It gives courts the power to make all manner of policy calls, including about how to weigh competing goods and values. (See *Chevron* itself.) It puts courts at the apex of the administrative process as to every conceivable subject—because there are always gaps and ambiguities in regulatory statutes, and often of great import. What actions can be taken to address climate change or other environmental challenges? What will the Nation's health-care system look like in the coming decades? Or the financial or transportation systems? What rules are going to constrain the development of A.I.? In every sphere of current or future federal regulation, expect courts from now on to play a commanding role. It is not a role Congress has given to them, in the APA or any other statute. It is a role this Court has now claimed for itself, as well as for other judges.

And that claim requires disrespecting, too, this Court's precedent. There are no special reasons, of the kind usually invoked for overturning precedent, to eliminate *Chevron* deference. And given *Chevron*'s pervasiveness, the decision to do so is likely to produce large-scale disruption. All that backs today's decision is the majority's belief that *Chevron* was wrong—that it gave agencies too much power and courts not enough. But shifting views about the worth of regulatory actors and their work do not justify overhauling a cornerstone of administrative law. In that sense too, today's majority has lost sight of its proper role.

And it is impossible to pretend that today's decision is a one-off, in either its treatment of agencies or its treatment of precedent. As to the first, this very Term presents yet another example of the Court's resolve to roll back agency authority, despite congressional direction to the contrary. See *SEC* v. *Jarkesy*, 603 U. S. ___ (2024); see also *supra*, at 3. As to the second, just my own defenses of *stare decisis*—

my own dissents to this Court's reversals of settled law—by now fill a small volume. See *Dobbs*, 597 U. S., at 363–364 (joint opinion of Breyer, SOTOMAYOR, and KAGAN, JJ.); *Edwards* v. *Vannoy*, 593 U. S. 255, 296–297 (2021); *Knick* v. *Township of Scott*, 588 U. S. 180, 207–208 (2019); *Janus*, 585 U. S., at 931–932. Once again, with respect, I dissent.

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UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

UNPUBLISHED
Court of Appeals of Virginia.

Kristin Lynn BURNS
v.
Kenneth William SULLIVAN

Record No. 1566-22-4
|
September 12, 2023

FROM THE CIRCUIT COURT OF FAIRFAX COUNTY, Richard E. Gardiner, Judge

Attorneys and Law Firms

(Kristin Lynn Burns, on brief), pro se.

No brief for appellee.

Present: Judges Humphreys, White and Retired Judge Frank [*]

MEMORANDUM OPINION [**]

PER CURIAM

***1** Kristin Lynn Burns (mother), *pro se*, appeals an order appointing Kenneth William Sullivan (father) guardian for their adult son (son). Mother argues that the circuit court erred by accepting father's petition and appointing a **guardian** ad **litem** (GAL) for son "without notice to any potential parties." She further alleges that the circuit court erred in permitting the GAL to waive son's legal rights in the proceeding and failing to compel son's participation in the hearing. Mother also asserts that the circuit court erred by failing to hold an "expedient [sic] status hearing" so it could address the "health and safety" of son and the parties' minor daughter and then hold an evidentiary hearing to terminate father's custodial rights to daughter and guardianship of son. In addition, mother contends that the circuit court erred by denying her access to son's mental health records and relied on "inadequate evidence" to establish son's incompetence. She also claims that the circuit court failed to consider "less restrictive alternatives" than the guardianship. Finally, she argues that the circuit court erred by entering an "indefinite" guardianship, sealing the files, and denying her post-trial motions. After examining the brief and record in this case, the panel unanimously holds that oral argument is unnecessary because "the appeal is wholly without merit." Code § 17.1-403(ii)(a); Rule 5A:27(a). For the following reasons, we affirm the circuit court's judgment.

BACKGROUND [1]

In reviewing a trial court's decision on appeal, "we view the evidence in the light most favorable" to father as the prevailing party, granting him the benefit of any reasonable inferences. *Shah v. Shah*, 70 Va. App. 588, 591 (2019) (quoting *Congdon v. Congdon*, 40 Va. App. 255, 258 (2003)).

Mother and father are divorced and are the parents of an adult son, who is the subject of this appeal. [2] The parties have an extensive litigation history with the circuit court and this Court. *See, e.g.*, *Burns v. Sullivan*, Nos. 0381-19-4, 1879-17-4, 0310-17-4, 0130-17-4, 1156-16-4, 0406-16-4, 1816-15-4, 0540-14-4, 0222-14-4, 2115-12-4, and 1040-12-4. In 2014, after finding that mother is a "vexatious litigant," the circuit court "restrained and enjoined [her] from further filings" in its court "or in any other court of the Commonwealth of Virginia without first obtaining leave of the court in which the action is to be instituted" (the pre-filing injunction order). [3] The circuit court instructed mother on how she was to obtain leave of court to file a motion, including filing a motion requesting leave and providing a copy of the pre-filing injunction order and a copy of the motion or pleading that she seeks to file.

***2** Over the years, father has sought mental health services and medication for son, who has been diagnosed with autism spectrum disorder, pervasive developmental disorder, disruptive mood dysregulation disorder, generalized anxiety disorder, parent-biological child conflict, and unspecified psychosis not due to a substance or known physiological condition. Father has obtained services and support for son through the Community Services Board and The Arc of Northern Virginia. Due to his mental health, son has been hospitalized on "multiple occasions," including month-long stays in 2020 and 2021. In addition, the police have responded to numerous situations involving son and his mental health.

In September 2021, son turned 18 years old, and on February 16, 2022, father petitioned to be appointed as son's guardian. Father claimed that son was "unable to make rational decisions regarding his wellbeing, perform perfunctory activities of daily living, and ... manage his medication properly, all of which create a substantial danger to his well-being and safety." Father's petition named mother as one of son's living relatives. Approximately one week after father filed the petition, the circuit court appointed a GAL for son.

The GAL subsequently met son at his temporary residence [4] and served him with a copy of the petition, exhibits, and the GAL appointment order. The GAL read the petition to son and advised him of his rights and the GAL's role. After the GAL read the petition to son, the GAL asked him if he consented to or opposed the petition. Son responded "inconsistent[ly]" because he initially said he opposed the petition and then said that he supported the petition.

Given his inconsistent responses, the GAL visited son a few weeks later. The GAL again informed him of the petition and his rights. After stating that he wanted his father to be his guardian, son "abruptly ended the conversation" and went back to bed.

After reviewing the relevant documents and interviewing mother, father, their teenage daughter, a "direct support professional" at the temporary residence where son was living, and the assistant director of services at The Arc of Northern Virginia, the GAL filed an answer to the petition and his report. The GAL reported that son had no known assets and father had applied for Social Security Disability Insurance benefits on son's behalf. The GAL noted that "[i]n accordance with Virginia Code § 64.2-2007," son "shall be regarded as having denied the allegations in the [p]etition." He also advised that it "could or would be adverse" to son's best interests to appear in court because it would likely be "disorienting" and cause him "to become agitated and/or act out." Considering reports of son physically assaulting father and damaging the walls in his room when he became "agitated," the GAL further opined that "it would be adverse" to son's best interests to return to father's home because he required a "managed care setting." The GAL noted that the professionals treating son reported that father had been "attentive and responsive" to son's needs and was "committed" to placing son in a residential setting that could meet his needs. Following his investigation, the GAL recommended that the circuit court adjudicate son "legally incompetent" and appoint father as son's guardian.

While the GAL was conducting his investigation, mother noted her appearance in the matter and requested leave to file a motion. Mother did not attach the motion she wished to file, so the circuit court found that she had not complied with the pre-filing injunction order. Mother filed a supplemental motion seeking an "ex parte protective order hearing" in the guardianship case, as well as the underlying custody matter. The circuit court found that it could "take no action" with her request in the custody matter because the circuit court judges had been recused from that matter in 2013. The circuit court denied mother's motion in the guardianship case but held that the ruling was "without prejudice to [mother] seeking leave to file the motion for guardianship," which appeared to be her intention in her motion for permission to file. Mother moved to reconsider the ruling, which the circuit court denied.

***3** Mother subsequently moved for leave to file another motion in the guardianship case and attached a proposed motion for the court's review. The circuit court granted mother's motion for leave to file the motion and emphasized that it was "*solely* with respect to the guardianship" of son. Mother then filed a motion seeking a status hearing relating to *both* of her children and alleging that father had abused them. The circuit court reviewed mother's motion, found that it was "not properly before the [c]ourt," and removed it from the docket. Mother filed a revised motion for a status hearing. The circuit court entered an order, finding that it did not have jurisdiction over the parties' daughter and denied the motion to modify custody of the daughter. The circuit court found, however, that mother was a party under Code § 64.2-2004(D) and entitled to participate in the guardianship proceeding, "where evidence may be presented." [5]

Thereafter, mother filed additional motions, seeking a "[j]udicially [a]pproved [s]tatus [h]earing." Mother again requested that the circuit court meet with both children "to determine ... how incapacitated [her] adult son is, the measure of health and capabilities [her] daughter has been able to maintain, and how to ensure both of [her] children [have] a healthier and happier future." The circuit court found that it "already heard and denied" mother's previous motion for a status hearing and her motion to reconsider. It also found that mother had not obtained leave of court to file her recent motion, so it denied her request for a status hearing. The circuit court also denied mother's request to view son's sealed medical records because under Code § 32.1-127.1:03(D)

(11), only **guardians** ad **litem** and attorneys representing the respondent have access to the records.

On September 14, 2022, father, by counsel, the GAL, and mother, *pro se*, appeared before the circuit court on father's petition.[6] The circuit court found that son was "unable to care for himself, manage his personal affairs, or effectively communicate his decisions regarding his health, safety, and treatment needs" due to his "mental illness." The circuit court further found that son needed a guardian "to facilitate his proper medical treatment and plan for his maximum self-reliance and independence to the extent possible, while protecting him from neglect, exploitation, or abuse." Considering all the evidence, the circuit court found that the "probable duration" of son's "incapacity, while unknown," was "not limited in duration." Finding that mother had not had any contact with son since 2013 and father had been "diligent" in seeking services to address son's mental health, the circuit court found that father was an "appropriate person" to serve as his guardian. Thus, the circuit court held that son was an "incapacitated adult" and appointed father as guardian. Finally, the circuit court ordered that "[t]his file and the fiduciary file created hereafter shall be sealed and no party, absent leave of [c]ourt granted upon the filing of a proper [m]otion, shall be allowed access to said file." Mother filed several post-trial motions, which the circuit court denied. Mother appeals.

ANALYSIS[7]

"[A]ll trial court rulings come to an appellate court with a presumption of correctness." *Sobol v. Sobol*, 74 Va. App. 252, 272 (2022) (quoting *Wynnycky v. Kozel*, 71 Va. App. 177, 192 (2019)). "In challenging the court's decision on appeal, the party seeking reversal bears the burden to demonstrate error on the part of the trial court." *Id.* at 272-73 (quoting *Barker v. Barker*, 27 Va. App. 519, 535 (1998)). "Even *pro se* litigants must comply with the rules of court." *Francis v. Francis*, 30 Va. App. 584, 591 (1999).

I. Appointment of **Guardian** ad **Litem**

***4** Mother challenges the circuit court's appointment of the GAL for son during the guardianship proceedings. She contends that the circuit court erred by "accepting" father's petition and "automatically appointing" the GAL "without notice to any potential parties." In addition, she asserts that the circuit court erred by "permitting" the GAL to "claim statutory authority to waive ... son's legal rights in the proceeding, rather than defend [his] legal presumption to be 'regarded as having denied the allegations in the petition' in [C]ode [§] **64.2**-2007(B)."

"[W]e review the trial court's statutory interpretations and legal conclusions *de novo*." *Chaney v. Karabaic-Chaney*, 71 Va. App. 431, 434 (2020) (quoting *Navas v. Navas*, 43 Va. App. 484, 487 (2004)). As mother concedes, Code § **64.2**-2002 does not require a petitioner to provide notice of the filing of the guardianship petition to the respondent or his relatives.

Code § **64.2**-2003(A) provides that "[o]n the filing of every petition for guardianship or conservatorship, the court shall appoint a **guardian** ad **litem** to represent the interests of the respondent." The circuit court does not have discretion in appointing a **guardian** ad **litem** because the statute directs the circuit court to do so "[o]n the filing of *every* petition." *Id.* (emphasis added). Code § **64.2**-2003(A) does not require a circuit court to provide notice to any party before appointing a GAL. Here, the circuit court followed the statutory requirements by appointing the GAL within one week of father filing the guardianship petition.

It appears that mother also challenges the GAL's recommendations against the appointment of counsel for son and his appearance before the court.[8] First, we note that the GAL advised the circuit court that Code § **64.2**-2007 required that son "be regarded as having denied the allegations in the [p]etition." In addition, the record reflects that after being appointed, the GAL personally served son with a copy of the petition, exhibits, and order appointing the GAL. The GAL advised son of his rights, including his right to counsel, and the GAL's role in the proceeding. As discussed in his report, the GAL explained to son that the GAL's role was different from legal counsel because the GAL is "an investigator" and has a "duty ... to make an independent assessment" of the situation. Although Code § **64.2**-2003 requires a circuit court to appoint a **guardian** ad **litem**, Code § **64.2**-2006 gives the circuit court discretion to appoint counsel "upon the filing of the petition or at any time prior to the entry of the order upon request of the respondent or the **guardian** ad **litem**, if the court determines that counsel is needed to protect the respondent's interest."[9] According to the GAL, son initially "vacillated" about whether he wanted a lawyer and agreed to father being appointed as his guardian. The GAL

discussed the situation further with son that same day, and son agreed to the appointment of father as his guardian; the GAL confirmed son's consent a few weeks later. Aside from an initial comment, nothing in the record before us suggests that son wanted court-appointed counsel; after speaking with him twice, the GAL confirmed that son agreed to father being his guardian.

***5** During his investigation, the GAL reviewed the psychological evaluations attached to the petition and interviewed son, his mental health providers, and father. The GAL concluded that it "could or would be adverse" to son's best interests to appear in court because he might "become agitated and/or act out" in the "disorienting" situation. Based on the record before us, the circuit court did not err in appointing a GAL for son. *See* Code § 64.2-2003. We further find that the circuit court did not abuse its discretion by not appointing counsel for him and not compelling his appearance in court.

II. Denial of Status Hearing

Mother argues that the circuit court erred by "failing to hold the expedient [sic] status hearing ... to address the health and safety" of both children. She claims that the status hearing would have offered both children an opportunity to "participate in the proceeding," "terminate" father's "custodial rights" to their daughter, and deny his petition for guardianship.

Upon mother's proper motion, the circuit court granted leave for her to file a motion "*solely* with respect to the guardianship" proceedings for son.

Notwithstanding the circuit court's clear limitation and the pre-filing injunction order, mother filed numerous motions seeking an "expedient status hearing" to "address the health and safety" of both of her children, terminate father's parental rights to their minor daughter, and "consider a relevant protective order" against father. The circuit court found that it did not have jurisdiction over the parties' daughter in the guardianship proceeding and denied mother's motion to modify custody. The circuit court granted mother the right to participate in the guardianship hearing, "where evidence may be presented."

Mother challenges the circuit court's ruling on appeal, but aside from citing the general principle of what constitutes a "clearly erroneous" finding, she has not cited any legal authority to support her specific arguments. Rule 5A:20(e) mandates that an appellant's opening brief include "[t]he standard of review and the argument (including principles of law and authorities) relating to each assignment of error." "[U]nsupported assertions of error do not merit appellate consideration." *Winters v. Winters*, 73 Va. App. 581, 597 (2021); *see also Buchanan v. Buchanan*, 14 Va. App. 53, 56 (1992) (same). Mother's "failure to provide legal argument and authority as required by Rule 5A:20(e) leaves us without a legal prism through which to view [her] alleged error and, therefore, is significant; accordingly, we deem [her] assignment of error waived." *Bartley v. Commonwealth*, 67 Va. App. 740, 746 (2017); *see also Coward v. Wellmont Health Sys.*, 295 Va. 351, 367 (2018) (same). Accordingly, we will not consider mother's arguments regarding her requests for a status hearing.

III. Waiver of Remaining Assignments of Error

Mother's appeal includes eight additional assignments of error that concern the custody of her daughter, access to son's medical records, the guardianship proceedings, father's appointment as guardian for son, and the denial of her post-trial motions. In her opening brief, however, she states that she was unable to include "arguments specifically related to" those eight assignments of error "in the timeframe" provided and "within page limit requirements." Nevertheless, she asks this Court to "accept these assignments of error for this appeal." We cannot do so. "Absent argument and authority, an assignment of error is deemed to be abandoned." *Lafferty v. Sch. Bd. of Fairfax Cnty.*, 293 Va. 354, 365 (2017); *see also* Rule 5A:20(e). Accordingly, we find mother's remaining assignments of error abandoned, and do not consider them. *Lafferty*, 293 Va. at 365.

CONCLUSION

***6** For the foregoing reasons, the circuit court's judgment is affirmed. [10]

Affirmed.

All Citations

Not Reported in S.E. Rptr., 2023 WL 5918054

Footnotes

* Retired Judge Frank took part in the consideration of this case by designation pursuant to Code § 17.1-400(D).

** This opinion is not designated for publication. *See* Code § 17.1-413(A).

1 The record in this case was sealed. We unseal only the specific facts stated in this opinion, "finding them relevant to our decision." *Daily Press, LLC v. Commonwealth*, —— Va. ——, —— n.1 (Oct. 20, 2022). "The remainder of the previously sealed record remains sealed." *Simms v. Alexandria Dep't of Cmty. & Hum. Servs.*, 74 Va. App. 447, 452 n.1 (2022) (quoting *Levick v. MacDougall*, 294 Va. 283, 288 n.1 (2017)).

2 The parties also have a minor daughter, of whom father has sole legal and physical custody. Following a hearing on December 17, 2013, the circuit court denied visitation to mother but ordered that she may petition for visitation after she had been "evaluated for her mental health status and for parental fitness by a licensed clinical psychologist or psychiatrist approved by the [c]ourt."

3 The pre-filing injunction order does "not apply to any appeal [mother] may wish to take from a decision of a trial court."

4 Son was hospitalized in early 2022 "due to a psychotic breakdown." Following his hospitalization, he resided in a crisis therapeutic home. He remained there until September 2022, when he transferred to a facility that specialized in supporting people with "intense behavioral needs."

5 The circuit court scheduled the final hearing on father's motion for September 14, 2022.

6 The record does not include a transcript or a written statement of facts in lieu of a transcript of the September 14, 2022 hearing.

7 Mother raises additional arguments in her amended opening brief that were not included in her assignments of error. Rule 5A:20(c) requires us to hold that these arguments are waived because they are not part of mother's assignments of error. *Fox v. Fox*, 61 Va. App. 185, 202 (2012). Therefore, we limit our review to the arguments listed in mother's assignments of error.

8 Our review of this argument is limited to the record before us, which does not include a transcript or a written statement of facts in lieu of a transcript from the circuit court hearing on father's petition. Mother admits that a court reporter was not present for the hearing but suggests that a recording from the courtroom may be available. Mother claims that she was "unable to obtain a copy" of the recording from the circuit court clerk's office and even if she could have obtained it, the cost of transcribing the recording was "cost-prohibitive." Mother asks this Court to request the circuit court to provide the transcript "without charge" to the parties. We cannot do so. "The burden is upon the appellant to provide [the appellate court] with a record which substantiates the claim of error." *Dixon v. Dixon*, 71 Va. App. 709, 716 (2020) (alteration in original) (quoting *Robinson v. Robinson*, 50 Va. App. 189, 197 (2007)). Moreover, Rule 5A:8(c) permits a party to submit a written statement of facts in lieu of a transcript, which mother failed to do.

9 In 2022, the General Assembly amended Code § **64.2**-2003(B) to require a **guardian** ad **litem** to notify the court "as soon as practicable if the respondent requests counsel regardless of whether the **guardian** ad **litem** recommends counsel." 2022 Va. Acts ch. 381. The amendment took effect after both meetings between the GAL and son; nonetheless, the GAL included in his report that son had "vacillated" initially about wanting a lawyer and agreeing to the guardianship but shortly thereafter consented to father being his guardian.

10 On March 13, 2023, father, *pro se*, moved to dismiss the appeal for mother's failure to provide a transcript of the proceeding. We deny father's motion because filing a transcript is not a jurisdictional requirement; thus,

not filing a transcript does not warrant grounds for dismissal of an appeal. *See* *Smith v. Commonwealth*, 281 Va. 464 (2011); *Browning v. Browning*, 68 Va. App. 19 (2017).

In June 2023, mother filed a motion for sanctions, and an amended motion for sanctions, because father failed to notify her of his motion. Mother also asks this Court to maintain paper files of electronic filings and order circuit courts to do the same, direct the circuit court to unseal the record in this case and provide a transcript of the final hearing, compel father and the children to remain in Fairfax County and provide mother with their contact information, and allow her "to communicate in person, by telephone, and via email" with the children. We do not have jurisdiction to consider any matters regarding the daughter because she is not the subject of this appeal. We deny mother's motion as to all other matters raised.

Mother also filed a motion for emergency injunctive relief in the Court on June 26, 2023. We deny this motion as well.

2024 WL 780603
Only the Westlaw citation is currently available.

UNPUBLISHED
Court of Appeals of Virginia.

Keith Alan BRADSHAW
v.
ESTATE OF Thomas Owens WATSON

Record No. 1782-22-2
|
February 27, 2024

FROM THE CIRCUIT COURT OF NOTTOWAY COUNTY, Paul W. Cella, Judge

Attorneys and Law Firms

Keith Alan Bradshaw, pro se.

(Clay L. Macon; Konstantine Kastens; Glasser & Macon, P.C., on brief), for appellee. Appellee submitting on brief.

(Linda M. H. Tomlin; The Law Office of Linda M. H. Tomlin, PLLC), **Guardian** ad **litem** for appellant.

Present: Judges Athey, Fulton and Causey

MEMORANDUM OPINION *

JUDGE CLIFFORD L. ATHEY JR.

***1** Keith Alan Bradshaw ("Bradshaw") appeals from an October 24, 2022 order entered in the Nottoway County Circuit Court ("circuit court") terminating a trust for which Bradshaw was a beneficiary. The order awarded attorney fees and costs to the trustee and **guardian** ad **litem** fees to the attorney appointed to represent Bradshaw. These awards were to be paid from the proceeds resulting from terminating the trust. Bradshaw, *pro se*, contends that the circuit court erred by awarding attorney fees and costs to the trustee and **guardian** ad **litem** from the proceeds resulting from terminating the trust. We disagree, and for the following reasons affirm the circuit court's order.

I. BACKGROUND

In 2003, Thomas Owens Watson ("Watson") executed his last will and testament, which created a trust containing $50,000 for the sole benefit of Bradshaw. The will named Bradshaw's brother, Steven K. Bradshaw ("Steven/trustee"), as trustee of the resulting trust. The trust created by the will instructed Steven to utilize the trust assets to purchase certain real estate for the benefit of his brother; however, in the event that said real estate could not be purchased within 20 years, he was to distribute the trust principal and interest to his brother. Watson's will also included the following provisions, relevant to this appeal. Article I stated: "I direct that all of my lawful unsecured debts, funeral expenses, expenses of my last illness, expenses of administration and taxes owed by my estate whether as a consequence of my death or otherwise, be paid out of my residuary estate without apportionment among the beneficiaries of my estate." Article III of the will stated: "[t]o the extent permitted by law, neither the principal nor income [of the trust] shall be liable for the debts of any beneficiary," before concluding that "[i]n addition to the powers granted by law, I grant to my Trustee those powers set forth in Section 64.1-57 of the Code of Virginia, as in force from time to time, and I incorporate that Code Section in said trust by this reference." In addition, Article V devised the entirety of Watson's residuary estate to Steven, who was also nominated in Watson's will to serve as executor pursuant to Article VI. Following Watson's death, Steven assumed his duties as both executor of the will and trustee of the resulting trust.

In his capacity as trustee, Steven filed a petition in the circuit court requesting aid and guidance because his brother, Bradshaw, the beneficiary of the trust, "is currently incarcerated at River North Correctional Center under a life sentence." Steven requested that the circuit court permit him to resign and either appoint a replacement trustee or simply terminate the trust and disburse the trust funds directly to an inmate trust account maintained for his brother's benefit. Since Bradshaw was incarcerated as the result of a felony conviction, the circuit court first appointed a **guardian** ad **litem** ("GAL") to represent his interests. *See* Code § 8.01-9. The GAL subsequently filed an answer to the petition on behalf of Bradshaw. The GAL agreed to Steven's request to be removed as trustee, to terminate the trust, and to distribute the trust assets into Bradshaw's inmate trust account.

***2** Hence, the circuit court held a hearing to consider the petition. Bradshaw appeared telephonically and upon his request, the circuit court permitted him to represent himself at the hearing since the GAL failed to appear. Finding that the parties agreed to the requested relief as proposed by Steven, the circuit court granted the requested relief and directed the counsel for Steven to "prepare an order terminating the trust and pay the money over to the gentleman as we described." On October 24, 2022, the circuit court entered a final order granting Steven's motion to resign as trustee, terminating the trust, and ordering the remaining principal and income to be paid into Bradshaw's inmate trust account. The final order also awarded reasonable attorney fees and costs to the trustee's counsel "to be paid from Trust assets," and $1,250 to the **guardian** ad **litem** for her services relating to the proceeding. The record indicates that an invoice prepared by the GAL documenting her work on the case was included with the final order when submitted to the circuit court. This invoice documented that the GAL incurred $1,250 in fees at an hourly rate of $250 per hour.

After receiving a copy of the final order, on November 4, 2022, Bradshaw wrote to his GAL expressing disagreement with the award of fees and costs in the order and asking her to assist him in having the circuit court modify the order. Bradshaw, acting *pro se*, mailed a letter dated November 7, 2022, to the presiding judge, challenging the fee awards to both the trustee's counsel and the GAL, arguing that under the terms of Watson's will, Watson's estate should bear those costs. [1] In the letter, Bradshaw asked the circuit court to amend its final order, remove the awards to the trustee's counsel and the GAL, and direct that the entirety of the trust funds be paid to Bradshaw. The trustee, by counsel, responded by letter mailed directly to the presiding judge arguing that the final order correctly reflects that the trust is responsible for the costs of the litigation. Subsequently, the circuit court sent an email to the trustee's counsel and the GAL advising them that he had received a letter directly from Bradshaw, but because the GAL represented Bradshaw, the circuit court would "treat [the letter] as an ex parte communication" and was "not going to read it." Bradshaw, again acting *pro se*, appealed from the circuit court's final order before sending another letter to the circuit court, *pro se*, expanding on the arguments in his previous letter and renewing his motion to amend the final order. [2]

II. ANALYSIS

A. *Standard of Review*

"We review an award of attorney's fees for abuse of discretion." *Lambert v. Sea Oats Condo. Ass'n, Inc.*, 293 Va. 245, 252 (2017) (citing *Manchester Oaks Homeowners Ass'n v. Batt*, 284 Va. 409, 429 (2012)).

B. *This Court has jurisdiction to hear this appeal because Bradshaw had no opportunity to contemporaneously object to the order of the trial court.*

As a preliminary matter, due to the unusual procedural history in this case, we choose sua sponte to address whether Bradshaw's assignment of error was preserved for appeal. Rule 5A:18 states "[n]o ruling of the trial court ... will be considered as a basis for reversal unless an objection was stated with reasonable certainty at the time of the ruling, except for good cause shown or to enable this Court to attain the ends of justice." However, Code § 8.01-384 states in relevant part, "if a party has no opportunity to object to a ruling or order at the time it is made, the absence of an objection shall not thereafter prejudice him on motion for a new trial or on appeal." "Plainly, this provision 'requires appellate courts to consider issues on appeal that do not satisfy the contemporaneous objection requirement when the litigant had no opportunity to make the requisite timely objection.' " *Jacks v. Commonwealth*, 74 Va. App. 783, 792 (2022) (en banc) (quoting *Maxwell v. Commonwealth*, 287 Va. 258, 265 (2014)). This exception applies when a litigant is denied the opportunity to make a contemporaneous objection "through no fault of his own." *Commonwealth v. Amos*, 287 Va. 301, 306 (2014).

***3** In *Maxwell v. Commonwealth*, the trial court recessed while the jury deliberated upon guilt. 287 Va. at 262. The parties left the courtroom during this time. *Id.* It later came to defense counsel's attention that during the recess, the jury made certain inquiries of the court, which the court answered without waiting for the parties to return. *Id.* at 262-63. On appeal, the Supreme Court decided that "by its plain language, Code § 8.01-384(A) prevents Maxwell from being prejudiced on appeal due to his lack of opportunity to make an objection contemporaneously with the court's act of proceeding in his absence." *Id.* at 267.

Similarly, in *Commonwealth v. Amos*, the Supreme Court addressed a situation in which the trial court held a witness in a criminal prosecution in contempt and remanded her to the custody of the sheriff without giving her any opportunity to address the court. 287 Va. at 304. The

Supreme Court found that "the exception is appropriate when circumstances such as those in this case arise" and concluded that because "the actions of the trial court prevented Ms. Amos from presenting a contemporaneous objection ... the contemporaneous objection exception of Code § 8.01-384(A) applies and no further steps were required to preserve her issues for appellate review." *Id.* at 309.

Likewise, in *Jacks v. Commonwealth*, "Jacks was convicted in the general district court for driving while intoxicated." 74 Va. App. at 787. He appealed his conviction to the circuit court on June 16, 2020, more than ten days after his conviction on March 16, 2020. *Id.* The circuit court denied the appeal as untimely. *Id.* Jacks noted an appeal arguing that because emergency orders issued by the Supreme Court in response to the Covid-19 pandemic tolled the filing deadline of Code § 16.1-132, the circuit court's denial of his appeal was in error. *Id.* Sitting en banc, this Court concluded that:

> Jacks had no opportunity to object to the circuit court's ruling at the time it was made. Because the circuit court mistakenly believed Jacks's appeal was untimely, it denied the appeal *sua sponte*, without a hearing, and outside the presence of Jacks or his counsel. In that way, Jacks lacked an opportunity to make a contemporaneous objection not through any fault of his own, but rather because the circuit court misunderstood the relevant procedural law when Jacks noted his appeal.

Id. at 792 (internal citations omitted).

Here, Bradshaw received the already executed final order of the circuit court. He did not see a draft of the order prior to its entry, nor does the record indicate that he had any contact with his GAL before she signed and submitted the final order to the circuit court for entry. Upon receiving a copy of the final, entered order, Bradshaw drafted a letter to the circuit court stating his objections to the final order and requesting that the circuit court reconsider the order. Upon receipt, the circuit court refused to read the letter, construing it as an ex parte communication. Bradshaw also wrote to his GAL expressing his objections to the order and requested her assistance in achieving a modification of the order. We note that the record is bereft of any indication that the GAL ever attempted to raise Bradshaw's concerns with the circuit court. Thus, Bradshaw was unable to make his objection known to the circuit court. This unfortunate situation occurred as a result of the circuit court reasonably failing to read the letter constituting an objection because Bradshaw was represented by a GAL who failed to bring the concerns of her client before the circuit court after being requested to do so by her client. Based on these unique facts, we find that Bradshaw, through no fault of his own, was denied the opportunity to contemporaneously object to the order of the circuit court. Therefore, pursuant to Code § 8.01-384(A), the appeal of the award of attorney fees and costs as well as the award of GAL fees was preserved, and this assignment of error is properly before this Court and will therefore be addressed on its merits.

C. *The circuit court did not abuse its discretion in awarding reasonable fees and costs.*

***4** Bradshaw contends that the circuit court abused its discretion by including in its final order an award of attorney fees and costs to be paid from the corpus of trust funds. Bradshaw makes three arguments in support of this position: (1) that the circuit court's oral pronouncement upon the conclusion of the hearing did not include this award, and therefore its inclusion in the written order was error; (2) the terms of the will which created the trust forbade payment of costs and fees from the trust corpus; and (3) that the fees awarded were unreasonable. [3] We disagree.

Bradshaw presents several cases, many from federal courts, supporting his basic proposition that because a defendant has a right to be present when he is sentenced, "if a conflict arises between the orally pronounced sentence and the written judgment, then the oral sentence controls." *United States v. Rogers*, 961 F.3d 291, 296 (4th Cir. 2020) (citing *United States v. Diggles*, 957 F.3d 551, 555, 557 (5th Cir. 2020)). He argues that the circuit court failed to award any attorney fees, GAL fees, or costs by pronouncement from the bench during the hearing and therefore any award of attorney fees, GAL fees, or costs in the final order was in error. However, the cases cited by Bradshaw specifically apply only to criminal sentencing and have no bearing upon this strictly civil matter.

Bradshaw also contends that the terms of the will required that the payment of the subject fees and costs were to be paid from Watson's residuary estate not from the trust corpus. We disagree.

Bradshaw relies upon three provisions in Watson's will. First, Bradshaw relies on Article I's provision: "I direct that all of my lawful unsecured debts, funeral expenses, expenses of my last illness, expenses of administration and taxes owed by my estate whether as a consequence of my death or otherwise, be paid out of my residuary estate without apportionment among the beneficiaries of my estate." Bradshaw contends that the attorney fees, GAL fees, and costs awarded by the circuit court in the final order are "expenses of administration" within the contemplation of Article I and therefore are to be paid out of the residuary of Watson's estate rather than the trust corpus. However, Bradshaw cites no authority for this interpretation of the will. Since Article III created the trust, we find that the plain meaning of Article I applies to the expenses of administering the decedent's estate, not the expenses in administering the trust created for Bradshaw's benefit.

Bradshaw next cites to Article III of the will: "[t]o the extent permitted by law, neither the principal nor income shall be liable for the debts of any beneficiary." Read in conjunction with the aforementioned provision in Article I along with the allocation of $50,000 to a trust for Bradshaw's benefit, Bradshaw seemingly argues that he was entitled to take the trust assets free and clear of any costs and that the fees and costs awarded by the order were "debts of the beneficiary [Bradshaw]" within the meaning of Article III of the will. Once again, Bradshaw cites no authority in support of this assertion. Although we acknowledge that this provision in Article III appears to be designating the resulting trust as a spendthrift trust, generally barring Bradshaw's creditors from being able to reach the assets of the trust in satisfaction of his debts, Article III does not preclude the circuit court from awarding costs and fees from the trust principal as it has done here.

***5** Article III of the will included a provision stating: "In addition to the powers granted by law, I grant to my Trustee those powers set forth in Section 64.1-57 of the Code of Virginia, as in force from time to time, and I incorporate that Code Section in said trust by this reference." Although Code § 64.1-57 has been repealed and replaced by Code § **64**.**2**-105(12), the new provision allows a trustee

> [t]o employ and compensate, out of the principal or income, or both as to the fiduciary seems proper, agents, accountants, brokers, attorneys-in-fact, attorneys-at-law, tax specialists, licensed real estate brokers, licensed salesmen, and other assistants and advisors deemed by the fiduciary to be needful for the proper administration of the trust or estate ....

This provision prevents the conclusion that Watson intended to completely insulate the $50,000 trust principal from any costs related to the trust.

In addition, Virginia law clearly contemplates trust assets being used to cover trust expenses including legal fees and costs. For example, Code § **64**.**2**-762 provides that "[a] trustee is entitled to be reimbursed out of the trust property, with interest as appropriate, for: (1) Expenses that were properly incurred in the administration of the trust ...." Also, Code § **64**.**2**-778(A)(15) provides that a trustee may "[p]ay taxes, assessments, compensation of the trustee and of employees and agents of the trust, and other expenses incurred in the administration of the trust[.]" Code § **64**.**2**-1065(A)(5) even permits for the disbursal of trust principal to pay "an expense of an accounting, judicial or nonjudicial proceeding, or other matter that involves primarily principal, including a proceeding to construe the terms of the trust or protect property[.]"

Therefore, we are unconvinced by Bradshaw's argument that an award of attorney fees and costs was precluded by Watson's will. No provision in the will forbade the award here, and the Code of Virginia expressly authorizes payment of certain trust expenses including fees for legal proceedings and attorney fees from trust assets. Further, Watson's will, by incorporation, expressly authorized the trustee to pay attorney fees and costs from the trust assets, thus undermining any argument that the testator sought to insulate the $50,000 in trust principal from the payment of any expenses.

Finally, Bradshaw seems to assert that the award of fees and costs here was unreasonable by suggesting that the GAL did not earn the fees she claimed and that the trustee petitioned the circuit court for his own benefit, not Bradshaw's, and therefore was not entitled to attorney fees and costs paid from the trust principal. Initially, we find that the issue of whether to award GAL fees is squarely within the discretion of the trial court. The record indicates that the trial court had the GAL's invoice before it when it decided to enter the proposed final order, and by implication the circuit court credited the invoice and found the award of fees reasonable

when it entered the proposed final order. Since we cannot conclude that no reasonable jurist could have credited the invoice, and found the award of fees reasonable, we find no error.[4] Bradshaw cites various cases in which awards to executors were found to be unreasonable because the executor was acting in his own rather than the beneficiary's interest. However, once again, since we cannot find that no reasonable jurist would have concluded that his trustee acted reasonably for the benefit of Bradshaw, we decline to disturb the payment of the attorney fees and costs incurred by the trustee from the trust principal.

III. CONCLUSION

***6** Thus, we disagree with Bradshaw's contention that the circuit court abused its discretion in awarding reasonable costs and fees to the trustee and **guardian** ad **litem** from the trust corpus and affirm the order of the circuit court.

Affirmed.

Causey, J., dissenting.

Bradshaw was not a party to this suit. The trial court exceeded its authority in assessing fees against Bradshaw by erroneously appointing a GAL for Bradshaw, finding that Bradshaw's GAL rendered "substantial service" as required by Code § 8.01-9, and awarding fees that neither the GAL nor petitioner's counsel argued at trial in violation of Bradshaw's constitutional right to due process. Furthermore, the trial court erred by not performing a colloquy before allowing a person it had found to be incapacitated (Bradshaw) to proceed without counsel. For these reasons, I respectfully dissent.

I. Fees

A. Petitioner's Attorney Fees

It was error for the trial court to award attorney fees to petitioner's counsel to be paid by the nonparty, Bradshaw. Our Supreme Court has clarified that "[w]hile '[a]n executor may, in good faith, seek the aid of counsel in the [e]xecution of his duties,' he is not entitled to attorneys' fees and legal costs simply because they were incurred in good faith." *Galiotos v. Galiotos*, 300 Va. 1, 12-13 (2021) (second and third alterations in original) (quoting *Clare v. Grasty*, 213 Va. 165, 170 (1972)). "The attorneys' fees and costs must be for services that aid the executor in the performance of his duties and are beneficial to the estate." *Id.* at 13; *see also O'Brien v. O'Brien*, 259 Va. 552, 557-58 (2000) (holding that an executor was rightfully denied attorney fees because the fees "were incurred for his personal benefit and not to benefit the estate or to aid him in his duties as an executor").

Here, it was an abuse of discretion to find that petitioner's counsel services aided the executor in the performance of his duties. Bradshaw did not contest Steven's course of action in resigning as executor and terminating the trust. Further, as reflected in the record, the trial court reached out to the parties, noting that "there seems to be an agreement that the trust should be terminated." The trial court went on to inform the parties that if they submitted an agreed order to that effect, the court would enter the order and the hearing would not be necessary. Ultimately, the hearing went forward, and as the transcript reflects, Bradshaw did not contest the termination of the trust nor the distribution of funds to his inmate account. Although the trustee may have brought this petition in good faith, petitioner's attorney fees and costs did not aid the trustee in his performance of his duties. Petitioner's course of action was uncontested by Bradshaw and forcing Bradshaw to bear these unnecessary legal fees is unjust. Simply put, there was no need for aid and direction because the court and the parties agreed prior to the hearing. Therefore, I would find that it was an abuse of discretion to award both the GAL fees and the petitioner's attorney fees.

B. GAL Fees

Bradshaw was appointed a GAL under Code § 8.01-9. As a preliminary matter, the Virginia legislature has provided a right to counsel in civil cases for defendants under a disability. *See* Code § 8.01-9. Code § 8.01-9 allows the appointment of a GAL—and the assessment of fees for that GAL—only for "[a] suit wherein a person under a disability is a party *defendant.*" (Emphasis added). A " '[p]erson under a disability' ... include[s] ... a person convicted of a felony during the period he is confined." Code § 8.01-2. However, in this case, the trial court erred when it appointed a GAL for Bradshaw. Despite his incarceration, Bradshaw does not qualify for a GAL under § 8.01-9 because he was not a defendant. Moreover, Bradshaw was not even a named party. Bradshaw appeared as the beneficiary of the trust, concurring with the trustee's petition to the court. As he was not a named

defendant, the court cannot assess Bradshaw the GAL fees under Code § 8.01-9.

***7** Since Bradshaw is not a defendant in this matter the trial court abused its discretion in finding him eligible to a right to counsel and appointing a GAL to represent him under Code § 8.01-9. Therefore, Bradshaw should not have to bear the burden of cost of counsel he never requested, never received, and was never authorized to be assigned under Code § 8.01-9. Indeed, any interpretation that Code § 8.01-9 automatically entitles all incarcerated persons to a GAL in their civil suits, regardless of whether they are a defendant or other party, would lead to an inequitable result. Although ideal, it would also provide incarcerated people with a blanket civil right to counsel that is badly needed, yet denied, for many law-abiding Virginia citizens.

Bradshaw is not a party to the case and should not be assessed any fees as a nonparty. Costs and fees in any case should only be assessed against the named parties. Here, a petition was filed by a trust's executor for aid and direction. Bradshaw himself was not ever named as a party to this suit. Although the petition was served on Bradshaw because he was the sole beneficiary of the trust, the record is void of any evidence of him being a named party before the trial court. And as noted by the court, they agreed. Therefore, if Bradshaw did not file the suit nor is he listed as a defendant/party, he should not be held responsible for *all* fees and costs associated with the suit. [5]

Even if Code § 8.01-9 did permit the GAL's appointment, the GAL in this matter failed to meet the statutory burden of rendering "substantial service" in representing her client's interests in order to receive compensation.

> When, in any case, the court is satisfied that the **guardian** ad **litem** has rendered substantial service in representing the interest of the person under a disability, it may allow the guardian reasonable compensation therefor, and his actual expenses, if any, to be paid out of the estate of the defendant.

Code § 8.01-9. In this case, there is no such finding in the court order granting the GAL's fees, no argument for GAL fees, and one would be hard pressed to find facts in the record that support a finding that such substantial services existed.

After being appointed, the GAL filed a half-page reply to the petition for aid and direction, failed to appear at the sole video/telephonic hearing, and filed a response to this appeal agreeing with the appellee—against her client's interests. Meanwhile, Bradshaw filed his own initial answer to the petition for aid and direction, filed his own motion to allow himself to appear for the court proceedings via video conference, represented himself at the hearing, attempted to lodge his objections with the court, and has defended his own appeal. The GAL's failure to attend trial or relay a client's valid objection to the court order could be considered a per se failure to render substantial services to a client.

Based on the record before this Court, there is no evidence to support that the GAL fulfilled the requirement of Code § 8.01-9 that the GAL render "substantial service in representing the interest" of Bradshaw and, therefore, her fees may not be awarded.

C. Attorney Fees versus Trust Expenses

***8** The majority errs by couching the trial court's award of attorney fees as trust expenses. "It is well-established that a court speaks only through its written orders." *S'holder Representative Servs., LLC v. Airbus Ams., Inc.*, 292 Va. 682, 690 (2016). Here, the court did not expressly find that the attorney fees were trust fees, it simply directed that the fees be paid out of trust assets. Without a finding that the attorney fees were trust expenses, this Court may not affirm the award on appeal.

Furthermore, the court order made an award of "reasonable attorneys' fees" to petitioner's counsel without any argument or evidence of attorney fees being presented at trial. Additionally, this award was not included in the judge's ruling from the bench. "[A]n attorney who seeks to recover legal fees ... must establish, as an element of the attorney's *prima facie* case, that the fees charged ... are reasonable." *Chawla v. BurgerBusters, Inc.*, 255 Va. 616, 623 (1998) (second and third alterations in original) (quoting *Seyfarth, Shaw, Fairweather & Geraldson v. Lake Fairfax Seven Ltd. P'ship*, 253 Va. 93, 96, (1997)).

> In determining whether a party has established a *prima facie* case of reasonableness, a fact finder may consider, *inter alia*, the time and effort expended by the attorney, the nature of the services rendered, the complexity of the services, the value of the services to the client, the results obtained, whether the fees incurred were consistent with those generally charged for similar services, and whether the services were necessary and appropriate.

Id. Although the trial court made an award of reasonable attorney fees, there is no evidence in the record to support that the attorneys in this case ever established a prima facie case of reasonableness. No evidence was presented or heard at trial. In fact, the transcript of the hearing in this matter is void of any mention of attorney fees. Furthermore, Bradshaw did not receive any notice of the award of attorney fees prior to receiving a copy of the executed order and never had a chance to object to the award. Therefore, it was error for the trial court to award attorney fees without the attorney establishing their prima facie case for the fees.

Unlike the majority, I do find Bradshaw's argument convincing that if attorney fees should be paid, they must be paid out of the residuary of the estate, not the principal of the trust. As noted above, this was an uncontested proceeding to remove Steven as trustee and terminate the trust. Bradshaw did not object to this course of action, and the court even noted that the parties seemed to agree regarding the disposition of the trust. Therefore, I agree that if anything this was an expense of the administration of the estate, not a necessary trust expense. Again, there was no need of aid nor direction. Accordingly, I would find that if attorney fees must be granted, they must be granted from the residuary estate, not the principal of the trust.

D. Bradshaw's Due Process Constitutional Right

Furthermore, attorney fees cannot be retroactively awarded without evidence or testimony presented at trial. At the conclusion of the hearing, the trial court asked petitioner's counsel to "prepare an order terminating the trust and pay the money over to the gentleman as described." Counsel responded that he would prepare the order and "circulate it, and [he would] bring [the GAL] up to speed as well." Following this exchange, there was a lengthy discussion regarding the proper place and manner for both the order and the funds to be sent to Bradshaw. Notably, the issue of attorney fees was never brought to the trial court's attention, and no affidavit of attorney fees incurred was submitted. Counsel drafted an order, which the trial court subsequently signed, which did not reflect the court's ruling from the bench as memorialized in the trial transcript—instead, the order counsel drafted added two provisions requiring Bradshaw to pay an open-ended "reasonable fee" not articulated at trial or in evidence. Trustee's counsel retained $6223.50 for these purposes.

***9** Clearly, the written order is not the same as the judge's ruling from the bench. As a preliminary concern, the court should be able to trust the attorneys practicing before it to transcribe judicial orders that accurately reflect what was ordered—and only such concessions as were ordered—at trial. As a secondary concern, the addition of elements into a judicial order that constitute considerable deprivations of property, without putting a party on notice or providing an opportunity to be heard, creates a constitutional due process violation.

The Supreme Court of the United States "consistently has held that some form of hearing is required before an individual is finally deprived of a property interest." *Mathews v. Eldridge*, 424 U.S. 319, 332 (1976); *see also Wolff v. McDonnell*, 418 U.S. 539, 557-58 (1974) ("The requirement for some kind of a hearing applies to the taking of private property."). "[T]he right to be heard before being condemned to suffer grievous loss of any kind, even though it may not involve the stigma and hardships of a criminal conviction, is a principle basic to our society." *Joint Anti-Fascist Comm. v. McGrath*, 341 U.S. 123, 168 (1951) (Frankfurter, J., concurring).

This due process interest is explicit not only in the Fifth Amendment of the United States Constitution, but also the Constitution of the Commonwealth of Virginia's guarantee "[t]hat no person shall be deprived of his life, liberty, or property without due process of law." Va. Const. art. I, § 11; U.S. Const. amend. V. This fundamental principle of our justice system requires that Bradshaw be given notice and the opportunity to be heard on the matter of these significant

attorney fees. *See Mathews*, 424 U.S. 319. Attorney fees should not be slipped into a judicial order after a hearing in which both attorneys failed to request them or submit evidence of them. To surprise Bradshaw with attorney fees in entry of the order, from an undisputed hearing for petition for aid and direction, is not warranted here.

II. Intelligent and Voluntary Waiver of Right to Counsel

The trial court further erred by allowing Bradshaw to waive the right to counsel (the GAL) during the hearing and represent himself. Once it ruled that Bradshaw required a GAL, the court was obligated to ensure that his right to that counsel was upheld during the pendency of the proceedings. Although the right to counsel is a fundamental constitutional right in criminal cases, a defendant may decide to waive his Sixth Amendment right to counsel. *Faretta v. California*, 422 U.S. 806, 814 (1975). However, "absent a knowing and intelligent waiver, no person may be imprisoned for any offense, whether classified as petty, misdemeanor, or felony, unless he was represented by counsel at his trial." *Argersinger v. Hamlin*, 407 U.S. 25, 37 (1972). "To be valid, any such waiver must be the voluntary act of the defendant and must constitute a knowing and intelligent abandonment of a known constitutional right or privilege." *McNair v. Commonwealth*, 37 Va. App. 687, 695 (2002) (citing *Edwards v. Arizona*, 451 U.S. 477, 482 (1981)).

In addition to the constitutional protections regarding waiver of the right to counsel, the General Assembly further prescribed the necessary steps for waiver in the Commonwealth of Virginia. The Code of Virginia requires that when a person, who is not represented by counsel, is accused of a crime for which incarceration may be the penalty the court is required to "ascertain by oral examination of the accused whether or not the accused desires to waive his right to counsel." Code § 19.2-160. If the accused chooses to waive his right to counsel and the court determines that such waiver is voluntarily and intelligently made, the court is required to provide the accused with a statement to be signed by the accused to document his waiver. *Id.* The waiver of right to counsel is detailed in the Code of Virginia and strictly adhered to in court proceedings.

***10** Here, the trial court made no determination that Bradshaw voluntarily, knowingly, or intelligently waived his right to counsel. The trial court, on its own volition, found it necessary to appoint a GAL for Bradshaw. However, the same trial court who found that Bradshaw required a GAL also found it appropriate to proceed in the GAL's absence. [6] The trial court did so without asking Bradshaw a single question regarding his waiver of right to counsel. Once petitioner's counsel was unable to establish contact with the GAL, Bradshaw asserted, "Your Honor, I'm prepared to proceed without [the GAL]," to which the court responded, "Yeah. I was going to say--go ahead sir. Go ahead sir." Thus, the trial court finding Bradshaw incapacitated and classifying him as under a disability, then allowing him to proceed without offering even a brief colloquy regarding the waiver of right to counsel, was an abuse of discretion. I would hold that the same colloquy required for a criminal defendant to waive their right to counsel in the Commonwealth of Virginia should also be required in civil cases where there is a right to counsel. Summarily, when a statute requires the right to counsel, the statute inherently also requires a knowing, voluntary, and intelligent waiver of that right to counsel. To hold otherwise would fail to effectuate the intent of the statutory protections provided to civil defendants by Code § 8.01-9.

III. Right to Civil Counsel

Finally, all civil defendants should be entitled to the right to counsel, regardless of disability. Code § 17.1-606 allows circuit courts in the Commonwealth of Virginia to assign counsel to any person who is

> (i) a plaintiff in a civil action in a court of the Commonwealth and a resident of the Commonwealth or (ii) a defendant in a civil action in a court of the Commonwealth, and who is on account of his poverty unable to pay fees or costs, may be allowed by a court to sue or defend a suit therein, without paying fees or costs.

The statute further provides that the person "shall have, from any counsel whom the court may assign him, and from all officers, all needful services and process, without any fees, except what may be included in the costs recovered from the opposite party." *Id.*

A study titled "Virginia Self-Represented Litigants Study," published by the National Center for State Courts, found that most civil cases in the Commonwealth have at least one unrepresented party. John E. Whitfield, *The Sobering Findings of the Virginia Self-Represented Litigants Study*, Va. Lawyers Weekly, June 2018, at 20. According to this study "[t]he traditional court model, in which both parties have legal representation, occurred in only one percent of district court cases." *Id.* at 21. The study also found that in juvenile and domestic relations district courts "neither party had representation in 87 percent of the cases, and only six percent of adult cases involved counsel representing both sides." *Id.* Further, the study found that in circuit court, 38 percent of cases had counsel for both parties. *Id.* In a sobering reality, the study revealed that "the greater extent of poverty in a locality, the more likely it is that parties would be unrepresented." *Id.* at 21-22. Not surprisingly, the study found that "[r]epresentational status has a clear impact on case outcomes, particularly when only one side or the other is represented." *Id.* at 23.

While the General Assembly has allowed for access to counsel in civil suits, as discussed above, many litigants are left to endure the legal system without the assistance of counsel. In this case however, simply because Bradshaw is incarcerated it is presumed that he is entitled to counsel in his civil suit. However, law abiding citizens are routinely denied access to counsel in their civil trials. Persons who are at risk of losing their home, children, employment, subject to garnishments, and various other civil suits are often forced to proceed without the assistance of counsel. But here, Bradshaw, who is serving a life sentence for taking the life of another, was presumed to have the statutory right to an attorney in his civil trial and received said counsel. Courts should more liberally use their powers under Code § 17.1-606 to protect law-abiding Virginia citizens in their civil suits and ensure equal access to justice in civil trials.

CONCLUSION

***11** For these reasons, I would find that the trial court erred by appointing a GAL for Bradshaw under Code § 8.01-9 because he was not entitled to counsel pursuant to this statute. I would also find that the trial court abused its discretion by awarding costs, GAL fees, and attorney fees to be paid by a nonparty in a suit, without notice. Bradshaw should not have to bear the cost of a suit that he did not bring and did not name him as a party. Further I would find that the trial court erred by not performing a colloquy to determine that Bradshaw was making a voluntary, knowing, and intelligent waiver of counsel. Therefore, I would reverse the trial court's award of the GAL and petitioner's costs and attorney fees and remand this case for further proceedings, consistent with this dissent.

All Citations

Not Reported in S.E. Rptr., 2024 WL 780603

Footnotes

* This opinion is not designated for publication. *See* Code § 17.1-413(A).

1 The GAL and counsel for the trustee are listed in the letter as recipients of carbon copies.

2 Bradshaw's GAL did not file a motion to amend on his behalf.

3 The dissent finds error with the trial court because Bradshaw was not a named party to the case and therefore could not have costs assessed against him. The dissent also finds the trial court erred by allowing Bradshaw to continue pro se at the hearing without first properly examining if his waiver of counsel was sufficiently knowing and intelligent. Bradshaw does not make these arguments, nor does his assignment of error encompass either. Therefore, we do not consider them. Rule 5A:20(e).

4 The dissent specifically relies upon the substantial service requirement of Code § 8.01-9 to conclude that the trial court erred in granting the GAL fees. We note that Bradshaw does not invoke Code § 8.01-9, and therefore we do not apply it. Rule 5A:20(e).

5 In other states, courts have likewise held that nonparties may not be assessed attorney fees in various cases. *See, e.g.*, *Hartloff v. Hartloff*, 745 N.Y.S.2d 363 (N.Y. App. Div. 4th Dept. 2002) (holding that the trial court did not have jurisdiction to assess counsel fees, costs, and sanctions against nonparties, where the nonparties had not been named as defendants in the action, had not been served with process notifying them of any claim for money damages, and had not been afforded the opportunity to defend such claim). *See also NRD Partners II, L.P. v. Quadre Investments, LP*, 875 S.E.2d 895, 899 (Ga. Ct. App. 2022) (holding that the trial court could not award attorney fees against a nonparty in a contempt sanction).

6 The GAL acknowledged receipt of the notice of hearing and even noted she planned to appear in person to make it easier to communicate with Bradshaw. The record makes it clear that both petitioner's counsel and the trial court believed the GAL would be appearing in person the day of the hearing. In fact, counsel for the petitioner tried to reach the GAL at the start of the proceedings, however, her phone went straight to voicemail. There is no evidence in the record to support that the GAL notified anyone that she could no longer attend the proceeding.

End of Document

2024 WL 3434797
Only the Westlaw citation is currently available.
Court of Appeals of Indiana.

IN RE the GUARDIANSHIP OF:
Anthony ADDUCCI, Incapacitated Person
Indiana Family and Social Services
Administration, Appellant-Intervenor
v.
Cheryl Adducci, Guardian for
Anthony Adducci, Appellee-Petitioner

Court of Appeals Case No. 23A-GU-2433
|
Filed July 17, 2024

Appeal from the Lake Superior Court, The Honorable Calvin D. Hawkins, Judge, Trial Court Cause No. 45D02-1905-GU-132

Attorneys and Law Firms

Attorneys for Appellant: Theodore E. Rokita, Indiana Attorney General, Evan Matthew Comer, Supervising Deputy Attorney General, Indianapolis, Indiana

Attorney for Appellee: Michael T. Foster, Greensburg, Indiana

Bradford, Judge.

Case Summary

***1** [1] In 2019, Cheryl Adducci was appointed guardian of her institutionalized husband Anthony, applied for Medicaid coverage on his behalf, and (before Anthony's Medicaid application had been approved) petitioned to divert some of his income for her support ("the Petition"), which petition the trial court granted (in "the Support Order"). The Indiana Family and Social Services Administration ("FSSA") provisionally granted Anthony's Medicaid application and eventually moved to intervene in the case and for relief from judgment, also arguing that the Support Order, which had the effect of increasing the amount FSSA must pay for Anthony's care, was unlawful. The trial court denied FSSA's motions to intervene and for relief from judgment and reiterated that the Support Order was lawful.

[2] FSSA argues that it had a right to intervene in the action because the Support Order diverted money to Cheryl that would have otherwise gone to pay Anthony's medical bills and it had no other way to challenge it. FSSA also argues that it was entitled to relief from judgment because it was a necessary party to the action who had not been served, rendering the Support Order void. Finally, FSSA argues that the Support Order is without legal basis. Because we agree with all of FSSA's contentions, we reverse the trial court's denials of FSSA's motions to intervene and for relief from judgment and remand with instructions.

Facts and Procedural History

[3] On May 31, 2019, Cheryl was appointed guardian of her husband Anthony, who had suffered a traumatic brain injury resulting in dementia and a brain aneurysm, leaving him unable to care for himself or his assets. On June 17, 2019, Cheryl filed, *inter alia*, the Petition. On July 2, 2019, Cheryl applied for Medicaid coverage on Anthony's behalf. On July 16, 2019, the trial court issued the Support Order, which allowed Cheryl to transfer up to $3275.00 of Anthony's income per month for her care, maintenance, and support. In August of 2019, the Adduccis notified FSSA of the Support Order. On August 30, 2019, FSSA approved Anthony's application for Medicaid coverage while also noting that, prior to the Support Order, he had not been eligible for Medicaid coverage because his income, as well as his and Cheryl's resources, exceeded applicable limits.

[4] On July 14, 2020, FSSA moved to intervene in the guardianship case and for relief from judgment, arguing that it was a necessary party because the Support Order meant that Indiana's Medicaid program (which is administered by FSSA) would have to pay for Anthony's care and that it was entitled to relief from judgment because it had not been served. During the litigation of FSSA's motions, FSSA also argued that the Support Order was unlawful because the mandatory fair hearing in the FSSA had never occurred, the doctrine of necessaries did not entitle Cheryl to spousal support, and Cheryl had violated her fiduciary duty to Anthony. The Adduccis argued that FSSA (1) had not moved for relief from judgment within a reasonable time, (2) had not been a necessary party to the guardianship proceedings, (3) and lacked standing to claim that Cheryl had violated her fiduciary duty. The Adduccis also argued that Indiana Code section 12-15-2-25 ("the State Medicaid Statute") and the doctrine of necessaries supported the Support Order.

***2** [5] On September 14, 2023, the trial court denied FSSA's motions to intervene and for relief from judgment and, alternatively, concluded that FSSA was barred from taking

advantage of the equitable remedy of relief from judgment because it had not engaged in mandatory rulemaking pursuant to Indiana Code section 12-15-2-25(d) and, therefore, had unclean hands. The trial court also concluded that Cheryl's allowance was supported by the State Medicaid Statute and the doctrine of necessaries.

Discussion and Decision

I. Background

[6] In the Medicaid program, the federal government provides funding to states, which in turn reimburse qualifying individuals for the cost of medical care. *Wis. Dep't of Health & Fam. Servs. v. Blumer*, 534 U.S. 473, 479, 122 S.Ct. 962, 151 L.Ed.2d 935 (2002) (citing *Schweiker v. Gray Panthers*, 453 U.S. 34, 36–37, 101 S.Ct. 2633, 69 L.Ed.2d 460 (1981)). For institutionalized individuals, Medicaid starts with the presumption that the individual must pay all of his income, minus certain permitted deductions, to the institutions caring for him before he can qualify for assistance. *See Lowes v. Lowes*, 650 N.E.2d 1171, 1175 (Ind. Ct. App. 1995) ("Congress intended that all third party sources of income to which an applicant is entitled be exhausted before resort to the social welfare system.").

[7] It was eventually realized that this exhaustion requirement, at times, left the community spouse [1] with insufficient resources, which prompted Congress to pass the Medicare Catastrophic Coverage Act of 1988 ("the MCCA"). 42 U.S.C. § 1396r-5. The stated purpose of the MCCA was to "end th[e] pauperization of the community spouse by assuring that the community spouse has a sufficient—but not excessive—amount of income and resources available[.]" *Blumer*, 534 U.S. at 480, 122 S.Ct. 962. In some cases, an institutionalized spouse is permitted to transfer a "community spouse monthly income allowance" without that amount being counted against him for eligibility-determination purposes. 42 U.S.C. § 1396r-5(d)(3). The exact amount of the monthly income allowance is determined by subtracting a community spouse's actual monthly earnings from a "minimum monthly maintenance needs allowance" ("the Allowance"), which is set by the State. 42 U.S.C. § 1396r-5(d)(2)–(3). If this calculation results in a shortfall between the community spouse's monthly income and the Allowance, the community spouse's monthly income allowance becomes the difference between the two amounts. 42 U.S.C. § 1396r-5(d)(2).

[8] Either spouse may petition for a "fair hearing before the State agency[,]" *i.e.*, FSSA, to argue that the Allowance should be increased. 42 U.S.C. § 1396r-5(e)(2)(B); *see also* 42 U.S.C. § 1396a(a)(3) (defining "fair hearing"). Pursuant to this provision, the Allowance may be increased if the spouses establish "that the community spouse needs income, above the level otherwise provided by the [Allowance], due to exceptional circumstances resulting in significant financial duress." 42 U.S.C. § 1396r-5(e)(2)(B). In some cases, such as this one, the Allowance would have to be increased for the institutionalized spouse to be eligible for Medicaid benefits at all.

[9] At the state level, the State Medicaid Statute provides that institutionalized Medicaid recipients who have a community spouse may "retain an income allowance for the purpose of supporting a community spouse" if "(1) the community spouse's income is less than the [Allowance]" established under federal law; and "(2) an increased amount is necessary to increase the community spouse's income to the [Allowance]." Ind. Code § 12-15-2-25(b). The State Medicaid Statute provides that "[i]f either spouse establishes that a higher allowance is needed due to exceptional circumstances resulting in significant financial duress, the [Allowance] may be increased *after an administrative hearing or by a court order.*" Ind. Code § 12-15-2-25(c) (emphasis added).

II. Intervention

***3** [10] FSSA contends that, because it was a necessary party to the guardianship action, the trial court abused its discretion in denying its motion to intervene. Motions to intervene in an action involve a mixed question of law and fact, and trial courts have discretion to determine whether a movant has met its burden of showing that it is entitled to intervene. *Citimortgage, Inc. v. Barabas*, 975 N.E.2d 805, 812 (Ind. 2012). A trial court's ruling on a motion to intervene is reviewed for an abuse of discretion, and the facts alleged in the motion are taken as true. *JPMorgan Chase Bank, N.A. v. Claybridge Homeowners Ass'n, Inc.*, 39 N.E.3d 666, 669 (Ind. 2015). An order denying a motion to intervene will be reversed if the decision is "clearly against the logic and effect of the facts and circumstances before the court or if the court has misinterpreted the law." *Abbott v. State*, 183 N.E.3d 1074, 1083 (Ind. 2022).

[11] Intervention is the procedure through which nonparties may assert their rights in an ongoing lawsuit. *See Citimortgage*, 975 N.E.2d at 812. Indiana's intervention procedures are governed by Indiana Trial Rule 24, which "expressly recognizes the right of a party to intervene after judgment for the purposes of presenting a motion under

Trial Rule 60." *Id.* Mandatory intervention is governed by Subsection (A)(2), which provides that a trial court *must* permit a third party to intervene in an action

> when the applicant claims an interest relating to a property, fund or transaction which is the subject of the action and he is so situated that the disposition of the action may as a practical matter impair or impede his ability to protect his interest in the property [...] unless the applicant's interest is adequately represented by existing parties.

Ind. Trial Rule 24(A)(2).

[12] Keeping in mind that facts alleged in FSSA's motion to intervene must be accepted as true, FSSA has established a clear interest in this proceeding, specifically that

> [t]he FSSA is harmed by the Court's Order because [...] the community spouse's income allowance is deducted from the amount of income that a Medicaid member must pay to his or her long-term care institution post-eligibility. Therefore, if the community spouse's income is artificially and unlawfully inflated above the limits established by statute, the institutionalized spouse will pay a lower proportion of his or her income to the institution, and the Medicaid Program will have to pay a higher amount to cover the remainder of the medical costs.

Appellant's App. Vol. II p. 51. Moreover, FSSA's ability to protect this interest is clearly impeded by this proceeding. As FSSA notes, it cannot adjust Cheryl's allowance on its own because it is bound by court orders on spousal support, even if erroneous.[2] Finally, it is undisputed that no party to the guardianship action, one result of which was the Support Order, adequately represented FSSA's interests. In summary, we have little hesitation in concluding that FSSA has a right to intervene in this action and that the trial court abused its discretion in denying its motion to do so. *See In re Guardianship of Weber*, 201 N.E.3d 220, 225–27 (Ind. Ct. App. 2022) (affirming the trial court's grant of FSSA's motion to intervene post-judgment where the court had ordered spousal support from an incapacitated spouse).

III. Motion for Relief from Judgment

[13] FSSA also contends that the trial court also abused its discretion in denying its motion for relief from judgment. Indiana Trial Rule 60(B) is an equitable form of relief that authorizes courts to reopen a previously-issued judgment for any of one of eight enumerated grounds, one of which is that the judgment is void. Ind. Trial Rule 60(B)(6); *In re Paternity of P.S.S.*, 934 N.E.2d 737, 740–41 (Ind. 2010). When a party moves for relief from judgment pursuant to Trial Rule 60(B)(6), the sole issue before the court is whether the judgment in question is void or valid. *Anderson v. Wayne Post 64, Am. Legion Corp.*, 4 N.E.3d 1200, 1205 (Ind. Ct. App. 2014), *trans. denied.*

***4** [14] "[A] judgment entered where there has been no service of process is void for want of personal jurisdiction." *Front Row Motors, LLC v. Jones*, 5 N.E.3d 753, 759 (Ind. 2014). Moreover, "a judgment that is void for lack of personal jurisdiction may be collaterally attacked at any time and [...] the 'reasonable time' limitation under Rule 60(B)(6) means no time limit." *Stidham v. Whelchel*, 698 N.E.2d 1152, 1156 (Ind. 1998). FSSA, a necessary party below, was never served, thereby depriving the trial court of personal jurisdiction over it, and the fact that it waited many months to act makes no difference. Consequently, the trial court abused its discretion in denying FSSA's motion for relief from the judgment pursuant to Trial Rule 60(B)(6).[3]

[15] FSSA contends that the trial court also abused its discretion by concluding that FSSA was not entitled to Rule 60(B) relief because it had failed to "adopt rules [...] setting forth the manner in which the office will determine the existence of exceptional circumstances resulting in significant financial duress[.]" Indiana Code Section 12-15-2-25(d). (Appellant's App. Vol. II p. 200). The trial court's identification of FSSA's failure to make rules for determining the existence of exceptional circumstances appears to invoke the equitable doctrine of "unclean hands":

> The principle of unclean hands is that he who comes into equity must come with clean hands. The doctrine of unclean hands is not favored and must be applied with reluctance and scrutiny. For the doctrine of unclean hands to apply, the misconduct must be intentional, and the wrong that is ordinarily invoked to defeat a claimant by using the unclean hands doctrine must have an immediate and necessary relation to the matter before the court.

Wedgewood Cmty. Ass'n, Inc. v. Nash, 781 N.E.2d 1172, 1178 (Ind. Ct. App. 2003), *trans. denied.*

[16] Under the circumstances, we fail to see why FSSA should be barred from pressing its claims by unclean hands. First, there is nothing in the record to suggest that FSSA's failure to make rules can fairly be characterized either as misconduct or intentional. Moreover, there is no immediate and necessary relation of FSSA's deferred rulemaking to the matter before the court, which had nothing to do with whether FSSA had incorrectly found that exceptional circumstances had not existed because of a lack of rules, but, rather, whether the Adducis had followed the proper procedure to obtain the Support Order.

IV. The Support Order

[17] Having concluded that the Support Order is void, we deem it necessary to provide guidance for the trial court regarding further proceedings by addressing the grounds the trial court cited to sustain the Support Order.

A. The State Medicaid Statute

[18] The trial court concluded that the State Medicaid Statute supports the Support Order, *i.e.*, the Support Order is justified by the trial court's finding of exceptional circumstances that would result in significant financial duress to Cheryl in the absence of support. FSSA contends that the Allowance cannot be increased without an administrative hearing, while the Adduccis contend that the trial court's finding of exceptional circumstances renders an administrative hearing unnecessary. We agree with FSSA. As mentioned, the MCCA *requires* a "fair hearing before the State agency" to determine if the Allowance should be increased, 42 U.S.C. § 1396r-5(e)(2)(B), and it is well-settled that "under the Supremacy Clause of the United States Constitution, federal law is the supreme law of the land." *Kuehne v. United Parcel Serv., Inc.*, 868 N.E.2d 870, 873–74 (Ind. Ct. App. 2007) (citing U.S. Const. art. VI, cl. 2; *Bondex Int'l v. Ott*, 774 N.E.2d 82, 85 (Ind. Ct. App. 2002)). "The preemption doctrine invalidates those state laws that interfere with or are contrary to federal law." *Id.* (citing *Cmty. Action Program of Evansville v. Veeck*, 756 N.E.2d 1079, 1084 (Ind. Ct. App. 2001)). "[S]tate law is [...] preempted to the extent it actually conflicts with federal law, that is, when it is impossible to comply with both state and federal law, or where the state law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress[.]" *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248, 104 S.Ct. 615, 78 L.Ed.2d 443 (1984). "The question, at bottom, is one of statutory intent, and we accordingly begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383, 112 S.Ct. 2031, 119 L.Ed.2d 157 (1992).

***5** [19] To the extent that the State Medical Statute may be read to allow for the Allowance to be increased without an FSSA hearing, it is in conflict with the MCCA's requirement of a "fair hearing before the State agency" and is therefore preempted. *See Blumer*, 534 U.S. at 478, 122 S.Ct. 962 ("The MCCA allows an increase in the standard allowance if either spouse shows, *at a state-administered hearing*, that the community spouse will not be able to maintain the statutorily defined minimum level of income on which to live after the institutionalized spouse gains Medicaid eligibility.") (emphasis added). Should the Adduccis wish to have the Allowance increased, they must first avail themselves of FSSA's administrative processes.

B. The Doctrine of Necessaries

[20] The trial court also concluded that the doctrine of necessaries justified Cheryl's increased allowance. In Indiana, the doctrine operates as follows:

> Each spouse is primarily liable for his or her independent debts. Typically, a creditor may look to a non-contracting spouse for satisfaction of

> the debts of the other only if the non-contracting spouse has otherwise agreed to contractual liability or can be said to have authorized the debt by implication under the laws of agency. When, however, there is a shortfall between a dependent spouse's necessary expenses and separate funds, the law will impose limited secondary liability upon the financially superior spouse by means of the doctrine of necessaries. We characterize the liability as "limited" because its outer boundaries are marked by the financially superior spouse's ability to pay at the time the debt was incurred. It is "secondary" in the sense that it exists only to the extent that the debtor spouse is unable to satisfy his or her own personal needs or obligations.

Bartrom v. Adjustment Bureau, Inc., 618 N.E.2d 1, 8 (Ind. 1993). "Agency requires some indicia that the principal intended or authorized the agent to conduct business on his or her behalf." *Hickory Creek at Connersville v. Estate of Combs*, 992 N.E.2d 209, 212 (Ind. Ct. App. 2013) (citing *Quality Foods, Inc. v. Holloway Assocs. Prof'l Eng'rs & Land Surveyors, Inc.*, 852 N.E.2d 27, 31–32 (Ind. Ct. App. 2006)). "Marriage alone is insufficient." *Id.*

[21] We conclude that the Support Order also cannot be sustained by operation of the doctrine of necessaries. First, Cheryl has failed to establish that Anthony has the ability to pay her expenses or is the financially-superior spouse. As mentioned, the limits of liability pursuant to the doctrine of necessaries are marked by the financially-superior spouse's ability to pay. *See Bartrom*, 618 N.E.2d at 8. The Support Order's findings indicate that, as of July of 2019, Anthony's monthly income from Social Security and a pension was $4960.50.[4] Anthony's obligations, however, have exceeded his income at all relevant times, starting at $5597.05 per month in July of 2019 and rising to $6919.51 per month by the end of 2021. Because Anthony's income does not even cover his own obligations (which, again, are his primary responsibility), *id.*, the Adduccis cannot establish that he has the ability to cover Cheryl's expenses or is financially superior to her. Moreover, the Adduccis point to nothing in the record that could support a finding that Anthony agreed to contractual liability to pay Cheryl's expenses or could be said to have authorized them by implication under the laws of agency. The Adduccis have failed to establish that the Support Order may be justified by the doctrine of necessaries.

***6** [22] The Adduccis do not actually claim that they have satisfied the elements of the doctrine of necessaries, arguing only that our decision in *Matter of Guardianship of Hall*, 694 N.E.2d 1168 (Ind. Ct. App. 1998), supports a spousal-support order in cases where one spouse's living expenses exceed that spouse's income. While this may be true in some situations, *Hall* is easily distinguished. In *Hall*, the guardianship estate of the institutionalized husband had assets of $176,705.45 and monthly income of $1789.00, while the wife had assets of $7055.52 and monthly income of $638.50. *Id.* at 1169. In short, the record supported a determination that the institutionalized spouse was financially-superior and able to cover wife's expenses, which is not the case here. In *Hall*, the record also supported an inference that the husband had impliedly agreed to cover the Wife's expenses before his incapacitation, as he had paid them after insisting that she cease her gainful employment. *Id.* at 1170. Again, there is nothing similar in the record before us here. The Adduccis' reliance on *Hall* is unavailing.

Conclusion

[23] We conclude that the trial court abused its discretion in denying FSSA's motion to intervene and in denying FSSA's motion for relief from judgment. Because we also conclude that neither the State Medicaid Statute nor the doctrine of necessaries sustains the Support Order, we remand with instructions to grant FSSA's motion to intervene, grant FSSA's motion for relief from judgment, and vacate the Support Order.[5]

[24] We reverse the judgment of the trial court and remand with instructions.

Circular reasoning that would always deprive a CS of entitlement to support.

Crone, J., and Tavitas, J., concur.

All Citations

--- N.E.3d ----, 2024 WL 3434797

Footnotes

1 In the Medicaid context, "[t]he term 'community spouse' means the spouse of an institutionalized spouse." 42 U.S.C. § 1396r-5(h)(2).

2 "If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered." 42 U.S.C. § 1396r-5(d)(5).

3 FSSA also argues that it is entitled to relief from judgment pursuant to Trial Rule 60(B)(2) (allowing for relief on "any ground for a motion to correct error") and 60(B)(8) (allowing for relief for "any reason justifying relief from judgment"). Because we have concluded that FSSA is entitled to relief from judgment pursuant to Trial Rule 60(B)(6), we need not address these other alleged grounds.

4 In its Brief of Appellant and in several filings below, FSSA puts Anthony's income at $3275.00 per month. The Adduccis, however, claimed in the Petition that Anthony's income was $4960.50 per month (as of July of 2019), and the record does not appear to contain any more recent information on the subject. Either way, Anthony's income is exceeded by his obligations.

5 We are aware that a probable consequence of our disposition is FSSA's withdrawal of Anthony's Medicaid coverage because, as mentioned, without the Support Order in place, the Adducci's income and assets are too large to qualify for Medicaid coverage. Nothing in this opinion, however, should be understood as preventing the Adduccis from again applying for Medicaid and/or attempting to increase the Allowance through FSSA's administrative processes.

End of Document

494 Mass. 198
Supreme Judicial Court of Massachusetts,
Suffolk.

Holly T. FREINER, personal representative, [1]
v.
SECRETARY OF the EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES & another. [2]

SJC-13514
|
Argued February 7, 2024.
|
Decided June 14, 2024.

Synopsis

Background: Married applicant for Medicaid long-term care benefits sought judicial review of decision by Office of Medicaid Board of Hearings denying his application. The Superior Court Department, Suffolk County, Maureen Mulligan, J., 2022 WL 22411782, denied applicant's motion for judgment on the pleadings and affirmed Board's decision, and David A. Deakin, J., entered final judgment. Applicant appealed, and appeal was transferred to the Supreme Judicial Court.

Holdings: The Supreme Judicial Court, Wendlandt, J., held that:

"refusal to cooperate," as used in Medicaid regulation allowing a married applicant to retain eligibility when the applicant's spouse refuses to cooperate by assigning to the Medicaid agency any rights to support from the spouse, requires that an applicant, who has a lengthy and ongoing history of marital collaboration, demonstrate more than only the spouse's refusal to supply the requisite financial information to the applicant;

substantial evidence supported Board's determination that applicant had not shown that his wife "refused to cooperate"; and

Board's denial did not violate applicant's procedural due process rights.

Affirmed.

Procedural Posture(s): On Appeal; Review of Administrative Decision; Motion for Judgment on the Pleadings; Motion for Attorney's Fees.

West Codenotes

Validity Called into Doubt
130 Mass. Code Regs. 517.011(A)

****251** Medicaid. MassHealth. Marriage. Regulation. Assignment. Administrative Law, Agency's interpretation of regulation. Due Process of Law, Administrative hearing. Words, "Refuses to cooperate."

CIVIL ACTION commenced in the Superior Court Department on April 9, 2020.

The case was heard by Maureen Mulligan, J., on a motion for judgment on the pleadings, and entry of separate and final judgment was ordered by David A. Deakin, J.

The Supreme Judicial Court on its own initiative transferred the case from the Appeals Court.

Attorneys and Law Firms DELETE

James R. Knudsen, Wakefield, for the plaintiff.

Cassandra Bolaños, Assistant Attorney General, for the defendants.

Patricia Keane Martin, Wellesley, Clarence D. Richardson, Jr., & C. Alex Hahn, for Massachusetts Chapter of the National Academy of Elder Law Attorneys, amicus curiae, submitted a brief.

Present: Budd, C.J., Gaziano, Kafker, Wendlandt, & Georges, JJ.

Opinion

WENDLANDT, J.

***199** This case arises at the intersection of Medicaid and marriage. The Medicaid program must preserve its limited resources to pay benefits only for those who are unable to afford care on their own. Consistent with that directive, the financial resources available to an applicant for Medicaid long-term benefits must fall below a threshold amount in order for the applicant to be eligible. When an applicant for long-term care benefits is married, determining eligibility requires a delicate balance. On the one hand,

the Medicaid program seeks to ensure that a financially secure couple cannot shift the burden of paying for the care of a married applicant (institutionalized spouse) onto Medicaid by sheltering assets under the name of the applicant's spouse (community spouse) in order to make the institutionalized spouse appear impoverished "enough" to meet the eligibility requirements for Medicaid benefits. On the other hand, the Medicaid program aims to avoid effectively impoverishing the community spouse by forcing the community spouse to spend virtually all the couple's assets before the institutionalized spouse can obtain benefits.

To address this challenge, Federal and State statutes and regulations govern how State Medicaid agencies must treat the resources available to the community spouse when determining the institutionalized spouse's eligibility. Before an institutionalized spouse may receive assistance, that spouse must disclose not only her own and the couple's joint resources, but also those resources ostensibly available only to the community spouse. A State Medicaid agency may not, however, deny the institutionalized spouse benefits because of resources determined to be available to the community spouse, if the institutionalized spouse assigns to the agency her rights to ****252** spousal support. This scheme allows the agency to attempt to recoup, through litigation if necessary, the benefits it paid on behalf of the institutionalized spouse from the resources available to the community spouse.

Recognizing that in some circumstances an institutionalized spouse may not be able to determine the community spouse's ***200** resources, Massachusetts's Medicaid program, MassHealth, [3] offers an additional protection for applicants; specifically, pursuant to 130 Code Mass. Regs. § 517.011 (2017) (regulation), if the community spouse "refuses to cooperate" or if that spouse's "whereabouts [are] unknown," MassHealth nonetheless will provide benefits to the institutionalized spouse even if the couple's combined resources cannot be calculated. [4] At issue in this case is the scope of the phrase "refuses to cooperate" in the regulation.

We conclude that MassHealth's board of hearings (board) reasonably construed the phrase "refuses to cooperate" to exclude the situation presented here, where the community spouse's principal act of noncooperation with the institutionalized spouse was the refusal to disclose her financial resources in connection with the institutionalized spouse's application for benefits from MassHealth. We agree with the agency's reasonable determination that, in the context of a "long-term and ongoing level of cooperation" throughout the marriage, such a refusal to disclose the community spouse's financial resources does not fall within the type of "refus[al] to cooperate" required by the regulation. Further concluding that the process resulting in the board's decision to deny the long-term care benefits in this case was not arbitrary or capricious, we affirm the decision of the Superior Court judge. [5]

1. Background. The following facts, as set forth in the administrative record, largely are undisputed. [6]

Costa and Mary Tingos were married in September 1957. The couple lived together for over fifty years, until May 2015, when Costa, [7] who was then eighty-two years old, moved into a residential nursing home.

As described by the couple, the marriage had its challenges; ***201** Costa had a long history of gambling problems and financial mismanagement, which eventually drove a wedge between the married couple. Indeed, at some point Mary considered divorcing Costa, but the couple remained married for religious reasons and because their two children "did not want [them] to get divorced."

Both spouses contributed financially to the marriage, albeit in unequal amounts. For much of the marriage, Mary worked consistently and paid the couple's major expenses, including the mortgage on the ****253** family home; [8] Costa also worked and contributed to the payment of utility and cable bills. Beginning sometime around 2003, Mary and Costa started keeping their income and assets "almost entirely separate." [9] They continued to live together in the family home and also continued filing their State and Federal income taxes jointly on the advice of their accountant.

When Costa moved into the nursing facility, Mary continued to assist her husband by helping coordinate his care. She also served as his attorney-in-fact under his power of attorney so she could manage his bank account and pay bills on his behalf.

2. Prior proceedings. a. Initial application. In September 2015, shortly after his admission into the residential nursing facility, [10] Costa filed an application for MassHealth long-term care benefits. In his application, Costa stated:

> "For decades my wife and I have kept our income and assets almost entirely separate, although I lived with her in her home and/or apartment and I contributed to some

> expenses such as cable[ ] and utilities. Mary is refusing to support me financially or cooperate with my application for benefits or provide information. I hereby assign to MassHealth my rights to obtain spousal support from her."

In response to a request from MassHealth, Costa disclosed certain financial information, including his and Mary's joint tax returns, but he did not provide additional requested information regarding Mary's income and assets.

In December 2015, MassHealth issued a denial letter. Citing ***202** 130 Code Mass. Regs. § 515.008 (2014), [11] MassHealth explained, "You did not give MassHealth the information it needs to decide your eligibility within the required time frame."

b. First hearing. Costa requested a hearing to review the denial of his application. [12] Costa asserted that "[he] should not be disqualified due to the refusal of [his] spouse to cooperate when [he] ha[d] assigned the division [his] right to support." A hearing was held in February 2016. In a written decision, the board denied Costa's administrative appeal, concluding:

> "[Costa] has not satisfied the provisions of 130 [Code Mass. Regs. §] 517.011. Specifically, ... [Costa] has not demonstrated by a preponderance of the evidence that his spouse will not cooperate. [Costa] did not submit any evidence, other than his own statement in a letter, to demonstrate that the spouse will truly not cooperate .... [Costa] did not produce any evidence from the community spouse, testimonial or otherwise, confirming her unwillingness to cooperate. Further, there was no evidence presented ****254** at or post-hearing regarding any efforts [Costa] has undertaken to compel the spouse to cooperate."

Costa sought judicial review of the board's decision, pursuant to G. L. c. 30A. In February 2018, a Superior Court judge vacated the decision, concluding that the denial letter had not given Costa sufficient notice that the reason for the denial was insufficient evidence of Mary's noncooperation; thus, he was not on notice that he would have to present such evidence at his hearing before the board. The judge remanded the matter to the board.

c. Second hearing. The board held a second hearing in May 2018, at which Costa testified that he had not asked Mary to provide the requested financial information; instead, he explained that his attorney had notified him of Mary's refusal to cooperate. In support of Costa's position at the hearing, Mary, who did not testify, submitted an affidavit. She averred, "I refuse to cooperate ***203** with my husband with his application for MassHealth long-term care benefits and I will not provide him with any information regarding my income, assets and other financial information."

The board again denied Costa's appeal, affirming the decision to deny his application for benefits. The board concluded that an applicant has a duty "to make reasonable efforts ... to access his spouse's income and assets ... [and Costa] has not demonstrated that he has made any [such] effort."

Costa sought judicial review of the board's decision, pursuant to G. L. c. 30A. In October 2019, a different Superior Court judge (second judge) vacated the board's decision and remanded the matter. The second judge concluded that Costa had not received sufficient notice that he would be required to demonstrate that he had made specific efforts to access Mary's financial information.

d. Third hearing. A third hearing was held before the board in January 2020. [13] MassHealth argued that Costa failed to demonstrate that he engaged in reasonable efforts to provide Mary's financial information, failed to demonstrate an inability to access information on her assets, and had "not presented evidence of [Mary's] bona fide refusal to cooperate with MassHealth but has shown a selective and opportunistic refusal depending on whether noncooperation is financially beneficial." Costa argued that he complied with his duty to make reasonable efforts to obtain Mary's financial information by providing the couple's joint tax returns, and that he had requested, through his attorney, financial information from Mary, but she had refused.

In March 2020, the board affirmed the denial of Costa's application, concluding:

> "[The record] suggest[s] a long-term and ongoing level of cooperation that fails to satisfy the requirements of 130 [Code. Mass. Regs. §] 517.011. In a determination of eligibility, MassHealth must evaluate the countable assets of both spouses (130 [Code Mass. Regs. §] 520.002[B][2][b]). [Costa] has not fully verified the couple's assets and has thus not fulfilled his duty to cooperate with the MassHealth agency to provide information necessary to establish eligibility."

***204** In reaching its conclusion, the board acknowledged Mary's stated refusal to provide information regarding her

finances, **255 but determined that Mary's "other actions, both past and present, belie the notion that she is a noncooperating spouse."

Costa [14] sought judicial review of the board's decision, pursuant to G. L. c. 30A. In February 2022, in a thorough and well-reasoned decision, a different Superior court judge (third judge) affirmed the board's decision. The third judge concluded that the board's construction of 130 Code Mass. Regs. § 517.011(B) was reasonable, that the construction was not inconsistent with Federal law, and that the board's decision to deny benefits was supported by substantial evidence. Costa timely appealed, and we transferred the matter to this court on our own motion.

3. Discussion. Our review of the board's decision denying Costa's application for benefits is limited; relevant here, we review such an agency decision to determine whether it is "[b]ased upon an error of law; ... [u]nsupported by substantial evidence; or ... [a]rbitrary or capricious, an abuse of discretion, or otherwise not in accordance with law." G. L. c. 30A, § 14 (7). See Massachusetts Inst. of Tech. v. Department of Pub. Utils., 425 Mass. 856, 868, 684 N.E.2d 585 (1997). A party challenging an administrative agency's decision "bears 'a heavy burden,' for we 'give due weight to the [agency's] expertise, as required by [G. L. c. 30A,] § 14 (7).' " Welter v. Board of Registration in Med., 490 Mass. 718, 724, 196 N.E.3d 312 (2022), cert. denied, —— U.S. ——, 143 S. Ct. 2561, 216 L.Ed.2d 1181 (2023), quoting Massachusetts Ass'n of Minority Law Enforcement Officers v. Abban, 434 Mass. 256, 263-264, 748 N.E.2d 455 (2001).

We review an agency's construction of its own regulation in the same manner that we would an agency construction of a statute it is tasked with administering. See Matter of the Estate of Mason, 493 Mass. 148, 152, 222 N.E.3d 1082 (2023). Specifically, we begin with "the text of the regulation, and will apply the clear meaning of unambiguous words unless doing so would lead to an absurd result." Welter, 490 Mass. at 726, 196 N.E.3d 312, quoting Massachusetts Fine Wines & Spirits, LLC v. Alcoholic Beverages Control Comm'n, 482 Mass. 683, 687, 126 N.E.3d 970 (2019). See DeCosmo v. Blue Tarp Redev., LLC, 487 Mass. 690, 699, 169 N.E.3d 510 (2021) ("If the regulation is plain and unambiguous, it should be interpreted according to its terms"). "Where the *205 plain text of the ... regulation[ ] is ambiguous, an agency's reasonable interpretation of [it] is generally entitled to deference." [15] Id. at 695-696, 169 N.E.3d 510. " '[W]e are generous in our deference to administrative agencies in their interpretation of their own regulations,' ensuring only that their interpretation is reasonable." Massachusetts Fine Wines & Spirits, LLC, supra, quoting Craft Beer Guild, LLC v. Alcoholic Beverages Control Comm'n, 481 Mass. 506, 527, 117 N.E.3d 676 (2019). See G. L. c. 30A, § 14 (7) ("The court shall give due weight to the experience, technical competence, and specialized knowledge of the agency, as well as to the discretionary authority conferred upon it"); **256 Carey v. Commissioner of Correction, 479 Mass. 367, 369, 95 N.E.3d 220 (2018) ("A plaintiff challenging an agency interpretation has a 'formidable burden' " [citation omitted]). This deference is not, however, "abdication"; we "will not hesitate to overrule agency interpretations of statutes or rules when those interpretations are arbitrary or unreasonable." Matter of the Estate of Mason, supra, quoting Armstrong v. Secretary of Energy & Envtl. Affairs, 490 Mass. 243, 247, 189 N.E.3d 1212 (2022).

a. Statutory framework. The Medicaid program is "a cooperative State and Federal program [intended] to provide medical assistance to individuals who cannot afford to pay for their own medical costs." Matter of the Estate of Mason, 493 Mass. at 153, 222 N.E.3d 1082, quoting Daley v. Secretary of the Executive Office of Health & Human Servs., 477 Mass. 188, 189, 74 N.E.3d 1269 (2017). See 42 U.S.C. § 1396-1 (Medicaid's purpose is to assist qualifying individuals "whose income and resources are insufficient to meet the costs of necessary medical services"). Within the framework established by Federal statute and attendant regulations, participating States have flexibility to design and operate their individual programs. Matter of the Estate of Mason, supra.

The Massachusetts State Medicaid program, MassHealth, makes benefits available for qualifying individuals who require long-term care services. See G. L. c. 118E, § 9; 130 Code Mass. Regs. § 519.006 (2023). Consistent with the Medicaid program's purpose of providing benefits only to those unable to afford care *206 on their own, see Dermody v. Executive Office of Health & Human Servs., 491 Mass. 223, 225-226, 201 N.E.3d 285 (2023), an applicant's countable assets cannot exceed a threshold amount, 130 Code Mass. Regs. § 520.016 (2013). [16]

Where the applicant is not married, the calculation is relatively straightforward, requiring disclosure and evaluation of that individual's own resources in order to determine the individual's eligibility. Where the applicant is married, the eligibility determination is more complex,

involving consideration of the needs and assets of a noninstitutionalized spouse who remains in the community.

If the State agency were to disregard entirely the community spouse's resources in determining a married applicant's eligibility, financially secure couples could shift the burden of paying for long-term care onto the State agency simply by placing their financial resources under the name of the community spouse. See Houghton v. Reinertson, 382 F.3d 1162, 1165 (10th Cir. 2004) ("a wealthy community spouse [could] shelter income and resources from inclusion in the calculation of the institutionalized spouse's eligibility"). Such maneuvering would permit a savvy couple to allow the institutionalized spouse to appear to fall within the eligibility requirement for long-term benefits, while hiding the couple's available resources and hoarding them away for the community spouse and family members. Permitting this loophole undermines the goal of Medicaid to preserve its benefits for the most needy. See, e.g., H.R. Rep. No. 100–105, 100th Cong., 1st Sess., pt. 2, at 73 (1987) (Committee on Energy and Commerce) (noting problem of "affluent individuals ... disposing of resources in order to qualify for Medicaid nursing home coverage" and that "Medicaid -- an entitlement program for the poor -- should not facilitate the transfer of accumulated wealth from nursing home patients to [family]").

By the same token, if MassHealth were to apply the same eligibility requirements **257 to a married applicant as it applied to an unmarried applicant, a community spouse might need to spend the couple's assets before the institutionalized spouse could qualify for benefits, potentially resulting in the " 'pauperization' of the community spouse." Wisconsin Dep't of Health & Family Servs. v. Blumer, 534 U.S. 473, 480, 122 S.Ct. 962, 151 L.Ed.2d 935 (2002), quoting H.R. Rep. No. 100–105, supra at 65. See Houghton, 382 F.3d at 1165 ("As *207 a result, some community spouses [could become] prematurely institutionalized themselves due to a lack of financial self-sufficiency"); H.R. Rep. No. 100–105, supra ("The purpose of the [Medicare Catastrophic Coverage Act[17]] is to end this pauperization by assuring that the community spouse has a sufficient -- but not excessive -- amount of income and resources available to her while her spouse is in a nursing home at Medicaid expense").

i. Required disclosure of couple's combined resources. To protect community spouses from such forced pauperization, and to eliminate loopholes that allowed well-resourced couples to shelter their resources under the name of the community spouse in order to allow the institutionalized spouse to appear qualified for Medicaid benefits, Congress enacted the "spousal impoverishment" provisions of the Medicare Catastrophic Coverage Act of 1988 (act or MCCA), 42 U.S.C § 1396r-5. See Thomas v. Commissioner of the Div. of Med. Assistance, 425 Mass. 738, 740, 682 N.E.2d 874 (1997) ("The MCCA addressed [the] problem" of prior law leaving "the community spouse financially vulnerable. ... At the same time, the MCCA was designed to eliminate loopholes which allowed couples to qualify for Medicaid even though they had substantial resources").

Pertinent here, the act imposes two requirements on State Medicaid agencies. First, when determining whether a married applicant is eligible for long-term benefits, an agency "must calculate the total value of the couple's resources" regardless of whether those resources are jointly owned or owned by one spouse in that spouse's sole name. Thomas, 425 Mass. at 740, 682 N.E.2d 874. See 42 U.S.C. § 1396r–5(c)(1)(A) ("There shall be computed ... the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest ..."). This permits the State agency to consider the entirety of the couple's finances without regard to the named ownership of the particular asset. Regardless of whether the asset belongs to one or both of the spouses, the asset is considered in the eligibility determination, eliminating the loophole that existed prior to the MCCA that permitted the couple to shelter assets in the name of the community spouse.

Second, the agency must determine, using a defined formula, the community spouse resource allowance (CSRA), which is a *208 portion of the couple's combined total resources calculated in the first step that is set aside for the community spouse's continued use. Thomas, 425 Mass. at 740, 682 N.E.2d 874. 42 U.S.C. § 1396r-5(f)(2). Significantly, the CSRA is not considered as a countable asset when determining the institutionalized spouse's eligibility. Thomas, supra at 740-741, 682 N.E.2d 874. 42 U.S.C. §§ 1396r-5(c)(2), (f)(2)(A). See Dermody, 491 Mass. at 227, 201 N.E.3d 285. By eliminating the CSRA from the eligibility determination for the institutionalized spouse, the MCCA preserves these resources for the community spouse, eliminating the preexisting situation that sometimes **258 resulted in the forced impoverishment of the community spouse.

Where a couple's combined total resources as calculated in the first step, less the CSRA amount, exceed the allowable

amount for Medicaid eligibility, the MCCA provides that the institutionalized spouse "shall not be ineligible by reason of [those] resources" for long-term Medicaid benefits if "the institutionalized spouse has assigned to the State any rights to support from the community spouse."[18] 42 U.S.C. § 1396r-5(c)(3). See, e.g., Morenz v. Wilson-Coker, 415 F.3d 230, 234 (2d Cir. 2005) (applicant eligible for long-term care benefits where State determined couple had excess resources but institutionalized spouse assigned support rights). Thus, an institutionalized spouse who executes the requisite assignment in favor of the State Medicaid agency will not be ineligible by reason of those resources to receive Medicaid benefits even though the couple's combined countable resources, which exclude the CSRA, exceed the threshold amount; in addition, the assignment allows the State agency to seek reimbursement of its costs from the community spouse.[19] Importantly, the provision applies only where the couple's total combined resources are disclosed to the State agency. This disclosure, ***209** in turn, permits the agency to determine whether seeking to pursue its assigned rights is worthwhile.

MassHealth follows each of these MCCA requirements. First, to determine the eligibility of an institutionalized spouse, MassHealth "must determine the couple's current total countable assets, regardless of the form of ownership between the couple." 130 Code Mass. Regs. § 520.016(B)(2). Second, MassHealth determines the CSRA based on the requisite formula, and that "allowance is not considered available to the institutionalized spouse when determining the institutionalized spouse's eligibility." Id. In addition, an institutionalized spouse "will not be ineligible due to ... assets determined to be available for the cost of care in accordance with 130 [Code Mass. Regs. §] 520.016(B) [based on the couple's total resources, less the CSRA] ... [if] the institutionalized spouse assigns to the MassHealth agency any rights to support from the community spouse." 130 Code Mass. Regs. § 517.011.[20]

***210** ****259** ii. Inability to calculate total resources. As discussed supra, the MCCA requires the institutionalized spouse to provide to the State Medicaid agency the information required to determine the couple's total combined resources. Access to such information often may necessitate the cooperation of the community spouse, for example, to disclose the resources held only in the community spouse's name. The Federal statute, however, does not address the circumstance in which the institutionalized spouse is unable to provide the information necessary to calculate the couple's total combined resources because, for example, the couple is estranged, making it infeasible for the institutionalized spouse to secure the information required from the community spouse.

To address this gap in the Federal scheme, MassHealth has promulgated the regulation, which provides a path to eligibility for an institutionalized spouse even if the couple's combined resources cannot be determined as required by 42 U.S.C. § 1396r–5(c)(1) and 130 Code Mass. Regs. § 520.016(B)(2). The regulation states:

> "An institutionalized spouse, whose community spouse refuses to cooperate or whose whereabouts is unknown, will not be ineligible due to ... [the institutionalized spouse's] inability to provide information concerning the assets of the community spouse when ... the institutionalized spouse assigns to the MassHealth agency any rights to support from the community spouse ...."[21]

130 Code Mass. Regs. § 517.011(B)(1). Thus, pursuant to the regulation, the institutionalized spouse is not ineligible for benefits ***211** by virtue of an inability to provide information concerning the community spouse's assets where (1) the community spouse "refuses to cooperate" or the community spouse's "whereabouts is unknown," and (2) the institutionalized spouse assigns to MassHealth any rights the institutionalized spouse may have to ****260** seek spousal support from the community spouse.[22] Id.

b. Refusal to cooperate. Costa contends that Mary's refusal to provide the financial information required to determine the couple's total combined resources, without more, satisfies the regulation's first requirement even though Mary and Costa were married and cohabited for decades, they shared financial responsibilities for payment of household expenses, they filed joint tax returns, Mary had Costa's power of attorney, and Mary continued to take care of Costa after he was placed in the nursing facility. In Costa's view, the regulation's use of the phrase "refuses to cooperate" encompasses the situation here where the community spouse's principal act of noncooperation is her refusal to cooperate in providing the financial information required for MassHealth to determine the couple's total combined resources. MassHealth contends that where, as here, the couple has a long-term and ongoing practice of cooperating, the isolated act of the community spouse refusing to provide the required financial information does not satisfy the regulation's requirement.

i. Construction of refusal to cooperate. To resolve the parties' dispute, we begin with the plain meaning of the phrase "refuses to cooperate." 130 Code Mass. Regs. § 517.011. See Matter of the Estate of Mason, 493 Mass. at 151-152, 222 N.E.3d 1082, quoting Harvard Crimson, Inc. v. President & Fellows of Harvard College, 445 Mass. 745, 749, 840 N.E.2d 518 (2006) ("We construe '[a] properly promulgated regulation ... in the same manner as a statute' " and "begin with [the] plain language"). The term "refuse" means "to show or express a positive unwillingness to do or comply with (as something asked, demanded, expected)." Webster's Third New International Dictionary 1910 (2002). The term "cooperate" means "to act or work with another or others to a common end" or "to ***212** associate with another or others for mutual ... benefit." Id. at 501. Thus, the phrase "refuses to cooperate" could encompass an unwillingness to collaborate on a specific task, including, as suggested by Costa, an isolated refusal to provide the requisite financial disclosure; or the phrase could refer to a more comprehensive unwillingness to collaborate or associate for mutual benefit, as MassHealth contends.

Of course, we do not read the words of the regulation in isolation. See Plymouth Retirement Bd. v. Contributory Retirement Appeal Bd., 483 Mass. 600, 605, 135 N.E.3d 702 (2019) ("Courts must look to the ... scheme as a whole ... so as to produce an internal consistency .... Even clear ... language is not read in isolation" [quotations and citations omitted]). A phrase "gains meaning from other[ ] [words] with which it is associated."[23] Commonwealth v. Gallant, 453 Mass. 535, 542, 903 N.E.2d 1081 (2009), quoting H.J. Alperin & L.D. Shubow, Summary of Basic Law § 19.10, at 846 (3d ed. 1996). See People for the Ethical Treatment of Animals, Inc. v. Department of Agric. Resources, 477 Mass. 280, 287, 76 N.E.3d 227 (2017), quoting Commonwealth v. Hamilton, 459 Mass. 422, 432, 945 N.E.2d 877 (2011) ("ordinarily the coupling of words denotes an intention that they should be ****261** understood in the same general sense"). Accordingly, "words and phrases used in a statute [or regulation] should be construed by reference to their associated terms in the statutory context." Morrison v. Lennett, 415 Mass. 857, 863, 616 N.E.2d 92 (1993). See Commonwealth v. Magnus M., 461 Mass. 459, 462, 961 N.E.2d 581 (2012), quoting Commonwealth v. Brooks, 366 Mass. 423, 428, 319 N.E.2d 901 (1974) (we "interpret 'words in a statute ... in light of the other words surrounding them' "); Black's Law Dictionary 1274 (11th ed. 2019) ("noscitur a sociis"; "the meaning of an unclear word or phrase, esp[ecially] one in a list, should be determined by the words immediately surrounding it").

Here, the phrase "refuses to cooperate" is followed immediately by the phrase "or whose whereabouts is unknown." 130 Code Mass. Regs. § 517.011. Both phrases modify the term "community spouse." Id. The second phrase, describing a community spouse "whose whereabouts is unknown," invokes a complete breakdown of the marital relationship such that the institutionalized spouse lacks even the basic knowledge of the community spouse's location. Construing "refuses to cooperate" ***213** in this context supports MassHealth and the board's construction that the phrase does not refer to the situation where the community spouse's principal act of noncooperation is failing to cooperate in the disclosure needed to calculate the couple's total combined resources for purposes of determining Medicaid eligibility. Including such an isolated refusal to cooperate alongside the sweeping inability even to locate the community spouse makes little sense.

The purpose of the Medicaid program, as well as the aim of the MCCA, further bolsters MassHealth and the board's construction of the regulation. See Dinkins v. Massachusetts Parole Bd., 486 Mass. 605, 608, 160 N.E.3d 613 (2021) ("the regulation here must be interpreted within the context of the larger statutory framework"). As we have previously noted, a core purpose of the Medicaid program is to preserve the Commonwealth's limited resources for those unable to afford medical care on their own. See Dermody, 491 Mass. at 226, 201 N.E.3d 285 (Medicaid amendments "have been attempts to ensure that Medicaid benefits go to those who need them rather than to those who can afford to pay"). To further that purpose, as discussed supra, Congress enacted the MCCA to close the preexisting loophole that allowed wealthy, financially savvy married couples to shelter their resources from the eligibility calculus simply by placing the resources in the community spouse's sole name.

Costa's construction would undermine the MCCA's goal to close this loophole by creating one that is virtually identical, further undermining the purpose of the Medicaid program to preserve resources for those in most need of assistance. Specifically, as before the MCCA, Costa's construction of the regulation would allow a couple to shelter assets by placing them in the community spouse's name, and then simply refusing to provide information about those assets in connection with the institutionalized spouse's application for benefits. See Atlanticare Med. Ctr. v. Commissioner of the Div. of Med. Assistance, 439 Mass. 1, 7 n.9, 785 N.E.2d 346 (2003) (rejecting interpretation of regulatory statute

that "would render largely meaningless the [superseding] Federal regulation"). By contrast, MassHealth and the board's construction of the regulation does not risk unraveling the protections in the MCCA. See Malloy v. Department of Correction, 487 Mass. 482, 496, 168 N.E.3d 330 (2021), quoting Attorney Gen. v. School Comm. of Essex, 387 Mass. 326, 336, 439 N.E.2d 770 (1982) ("we will not construe a **262 [provision] such that 'the consequences ... are absurd or unreasonable' *214 "). Accordingly, we conclude that the board reasonably construed the scope of the regulation by determining that "refusal to cooperate" requires that a married applicant, who has a lengthy and ongoing history of marital collaboration, must demonstrate more than only the community spouse's refusal to supply the requisite financial information to the institutionalized spouse.

ii. Mary's cooperation. Applying the agency's reasonable construction of the regulation, the board's determination that Costa has not shown that Mary "refuse[d] to cooperate" as required by the regulation is supported by substantial evidence.[24] See Medical Malpractice Joint Underwriting Ass'n of Mass. v. Commissioner of Ins., 395 Mass. 43, 55, 478 N.E.2d 936 (1985) ("Substantial evidence is such evidence as a reasonable mind might accept as adequate to support a conclusion ... upon consideration of the entire record, ... including whatever in the record fairly detracts from its weight" [quotations and citations omitted]); G. L. c. 30A, § 1 (6).

To be sure, the record reflects that Mary kept her finances separate from Costa, and MassHealth does not challenge Costa's position that the marriage suffered strife stemming from Costa's gambling and financial mismanagement. Nonetheless, the record also shows that the couple maintained long-standing and ongoing cooperation. The couple lived together for over fifty years until Costa's admission to the nursing facility, and they both contributed to household expenses. They eased their tax burden by filing taxes jointly, which inevitably requires some degree of financial collaboration. After Costa moved into the long-term care facility, Mary continued to cooperate with Costa; she helped coordinate his care, served as his representative under his power of attorney, managed his bank account, and paid his bills.

On this record, the board was warranted in determining that Mary's refusal to disclose her financial information to MassHealth did not meet Costa's burden under the regulation. The board could conclude reasonably that such selective noncooperation within the context of otherwise extensive collaboration in other aspects of the marital relationship was insufficient to constitute *215 the type of refusal to cooperate required by the regulation.

c. Procedural due process. Costa also challenges the denial of his application on the ground that the board's decisional process was ad hoc and arbitrary. As delineated above, the first and second judges determined that MassHealth and the board provided insufficient notice to Costa that resulted in his case being twice remanded for further proceedings. Nonetheless, we disagree that this circuitous route renders the ultimate outcome invalid.

"A decision is not arbitrary and capricious unless there is no ground which 'reasonable [persons] might deem proper' to support it." McCauley v. Superintendent, Mass. Correctional Inst., Norfolk, 491 Mass. 571, 598, 205 N.E.3d 295 (2023), quoting Garrity v. Conservation Comm'n of Hingham, 462 Mass. 779, 792, 971 N.E.2d 748 (2012). Here, the record does not support the claim that MassHealth and the board acted arbitrarily. MassHealth and the board did not concoct excuses for **263 denying Costa's application, did not rely on changing rationales, and did not otherwise act unreasonably. See Fafard v. Conservation Comm'n of Reading, 41 Mass. App. Ct. 565, 572, 672 N.E.2d 21 (1996) (agency criteria "devised for the occasion, rather than of uniform applicability" is arbitrary). Rather, each of the rationales for denying Costa's application related to MassHealth and the board's consistent position that the regulation requires more than merely stating that the community spouse has refused to divulge financial information. To the extent that Costa did not understand, during the first two hearings, the full scope of his burden to demonstrate Mary's refusal to cooperate, the misapprehension was cured by the subsequent hearing. See Yebba v. Contributory Retirement Appeal Bd., 406 Mass. 830, 837, 551 N.E.2d 488 (1990) (improper denial of opportunity to litigate issue before agency was remedied by subsequent opportunity do so).[25]

Judgment affirmed.

All Citations

494 Mass. 198, 235 N.E.3d 248

Footnotes

1 Of the estate of Costa Tingos.

2 Director of the board of hearings of the Office of Medicaid.

3 MassHealth is overseen by the Executive Office of Health and Human Services (EOHHS). The parties refer to the State Medicaid program and EOHHS as "MassHealth." For consistency, we do the same.

4 The institutionalized spouse still must assign spousal support rights to MassHealth or meet one of the other specified conditions.

5 We acknowledge the brief of amicus curiae Massachusetts Chapter of the National Academy of Elder Law Attorneys.

6 Our review is confined to the facts in the administrative record. See G. L. c. 30A, § 14 (5); BAA Mass., Inc. v. Alcoholic Beverages Control Comm'n, 49 Mass. App. Ct. 839, 840 n.2, 733 N.E.2d 564 (2000) ("review is confined to [the administrative] record").

7 Because Costa and Mary Tingos share the same surname, we refer to each by his or her first name.

8 After Costa stopped paying the mortgage on the family home, he transferred his ownership interest in the home to Mary by deed. The transfer occurred in 1983.

9 Costa did not have independent access to Mary's financial information.

10 Prior to his admission to the nursing home, Costa suffered paralysis to the left side of his body.

11 Title 130 Code Mass. Regs. § 515.008 provides, in relevant part: "The applicant or member must cooperate with the MassHealth agency in providing information necessary to establish and maintain eligibility."

12 See G. L. c. 118E, § 47 ("Any applicant for or recipient of medical assistance ... aggrieved by the failure of the division to grant medical assistance ... shall have a right to a hearing, after due notice, upon appeal to the division in the manner and form prescribed by the division"). See also 130 Code Mass. Regs. §§ 610.000 (2023) (prescribing hearing rules).

13 Costa was competent when he was admitted into the nursing facility, and at least as of June 2018. By January 2, 2020, the time of the third hearing before the board, Costa was no longer competent to testify. Costa was represented at the hearing by his attorney. His later lack of competency is not, however, raised as an issue here.

14 Costa died on May 28, 2020; his estate was substituted as a party to the proceedings. For purposes of consistency, we will continue to refer to Costa's estate as "Costa."

15 "In deciding whether deference is due to an agency's interpretation, [we] consider whether (1) the regulatory language is plain or ambiguous; (2) the agency's interpretation is reasonable; (3) the interpretation is the agency's official or authoritative position; (4) the interpretation draws on the agency's technical and substantive expertise; and (5) the agency's interpretation is based on fair and considered judgment" (footnotes omitted). DeCosmo, 487 Mass. at 699, 169 N.E.3d 510.

16 Income limits also apply. See 130 Code Mass. Regs. § 520.009 (2023).

17 Discussed infra.

18 In addition, an institutionalized spouse shall not be ineligible for benefits if

> "(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or
>
> "(C) the State determines that denial of eligibility would work an undue hardship."

42 U.S.C. § 1396r-5(c)(3). Neither of these provisions is at issue in this case.

19 In certain circumstances, married individuals have the ability to obtain a court order requiring payment of support from a spouse without a divorce. See G. L. c. 209, § 32; C.P. Kindregan, Jr., M. McBrien, & P.A. Kindregan, Family Law and Practice § 81 (4th ed. 2013).

20 The present matter concerns subsection (B) of 130 Code Mass. Regs. § 517.011; we note that subsection (A) of the regulation, as presently written, appears to contain what MassHealth has described as a "scrivener's error." Title 130 Code Mass. Regs. § 517.011 states in full:

> "An institutionalized spouse, whose community spouse refuses to cooperate or whose whereabouts is unknown, will not be ineligible due to
>
> "(A) assets determined to be available for the cost of care in accordance with 130 [Code Mass Regs. §] 520.016(B): Treatment of a Married Couple's Assets When One Spouse Is Institutionalized; or
>
> "(B) his or her inability to provide information concerning the assets of the community spouse when one of the following conditions is met:
>
> "(1) the institutionalized spouse assigns to the MassHealth agency any rights to support from the community spouse;
>
> "(2) the institutionalized spouse lacks the ability to assign rights to spousal support due to physical or mental impairment as verified by the written statement of a competent medical authority; or
>
> "(3) the MassHealth agency determines that the denial of eligibility, due to the lack of information concerning the assets of the community spouse, would otherwise result in undue hardship."

As discussed supra, the MCCA does not permit a State agency to deny benefits to an institutionalized spouse because of excess resources if the institutionalized spouse both (1) discloses the information necessary to determine the couple's total combined assets and (2) assigns to the State agency the right to spousal support. See 42 U.S.C. § 1396r-5(c)(3). The regulation appears to impose an additional requirement on an institutionalized spouse to show that the community spouse refuses to cooperate or that the community spouse's whereabouts are unknown. Such an additional requirement contravenes the Federal statute, which

must control. See Matter of the Estate of Mason, 493 Mass. at 153, 222 N.E.3d 1082; G. L. c. 118E, § 9 (MassHealth must operate "pursuant to and in conformity with [F]ederal law").

MassHealth has represented to this court that, irrespective of the drafting error in its regulation, it "complies with [42 U.S.C. § 1396r-5(c)(3)(A)] in all cases." We urge MassHealth to amend 130 Code Mass. Regs. § 517.011 to bring the plain language of subsection (A) of the regulation into compliance with Federal law.

21 Additional conditions may trigger the exception under 130 Code Mass. Regs. § 517.011, but are not at issue here:

> "(2) the institutionalized spouse lacks the ability to assign rights to spousal support due to physical or mental impairment as verified by the written statement of a competent medical authority; or
>
> "(3) the MassHealth agency determines that the denial of eligibility, due to the lack of information concerning the assets of the community spouse, would otherwise result in undue hardship."

22 It is undisputed that Costa assigned the rights to spousal support to MassHealth in his application, satisfying the second requirement of 130 Code Mass. Regs. § 517.011(B). The parties' dispute centers on whether the regulation's first requirement was satisfied.

23 This principle of construction is known as "noscitur a sociis," which is Latin for "it is known by its associates." Black's Law Dictionary 1274 (11th ed. 2019).

24 The Superior Court judges and hearing officers presumed, and Costa does not contest, that Costa bore the burden of demonstrating eligibility, including Mary's noncooperation, by a preponderance of the evidence. See 130 Code Mass. Regs. § 610.082(B) (2019) (board's "decision must be based upon a preponderance of evidence"); 130 Code Mass. Regs. § 519.006 ("Institutionalized individuals may establish eligibility for MassHealth Standard coverage subject to the following requirements").

25 Costa's request for appellate attorney's fees and costs is denied.

End of Document

2023 WL 6931925
Only the Westlaw citation is currently available.
Court of Appeals of Michigan.

Ralph HEGADORN, Personal Representative of the Estate of Mary Ann Hegadorn, Appellee,
v.
LIVINGSTON COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES, Appellant.

No. 356756
|
October 19, 2023, 9:10 a.m.

Synopsis

Background: Wife appealed decision of administrative law judge, which concluded that county department of health and human services properly denied wife's request for Medicaid benefits to pay for her long-term care, based on determination that assets in "solely for the benefit of" (SBO) husband trust were countable assets for Medicaid eligibility purposes. The Circuit Court, Livingston County, reversed, finding that SBO trust assets were not countable because SBO trust was created before department changed its policy regarding SBO trusts. On appeal, the Court of Appeals, 320 Mich.App. 549, 904 N.W.2d 904, reversed the circuit court's decision. The Supreme Court, 503 Mich. 231, 931 N.W.2d 571, reversed and remanded, holding that principal of an irrevocable trust formed solely for the benefit of a community spouse was not per se a resource available to an institutionalized spouse for purposes of Medicaid eligibility. Following ALJ's decision on remand again affirming denial of wife's Medicaid application, the Circuit Court, Livingston County, reversed the ALJ's decision, ordered department to approve wife's application for Medicaid benefits, and denied department's motion for reconsideration. Department appealed.

Holdings: The Court of Appeals, N. P. Hood, J., held that:

fact that husband and wife were married did not necessarily render assets in husband's SBO trust countable for purposes of determining wife's Medicaid eligibility;

fact that wife had assets available to her at time of initial assessment was not conclusive of assets available to wife for purposes of Medicaid eligibility;

trial court was required to determine whether supplemental care trust amounted to a circumstance under which SBO trust was making a payment for wife's benefit for purposes of Medicaid eligibility; and

without supplemental care trust document in record, it could not be determined whether assets placed in SBO trust were countable assets for purposes of wife's Medicaid eligibility.

Affirmed in part, vacated in part, and remanded.

Procedural Posture(s): On Appeal; Review of Administrative Decision.

Livingston Circuit Court, LC No. 20-000171-AA

Before: M. J. Kelly, P.J., and Cameron and N.P. Hood, JJ.

Opinion

N.P. Hood, J.

***1** Appellant Livingston County Department of Health and Human Services (MDHHS) appeals by leave granted [1] the circuit court order reversing the decision of the administrative law judge (ALJ), and awarding Medicaid benefits to the Estate of Mary Ann Hegadorn (the estate), whose personal representative is Ralph Hegadorn (Mr. Hegadorn). The broad issue, as before, is the eligibility of now-deceased Mary Ann Hegadorn (Mrs. Hegadorn or Mary Hegadorn) for long-term care Medicaid benefits and the impact of certain trust documents on her eligibility. The granular and decisive issue is whether there were any circumstances under which the proceeds of the "Ralph D. Hegadorn Irrevocable Trust No. 1 (Sole Benefit Trust)" (Hegadorn SBO Trust) could be paid to Mrs. Hegadorn or for her benefit. This necessarily required consideration of the terms of a second trust that the Hegadorn SBO Trust contemplated creating, but that is not part of the record. On remand, the administrative law judge failed to follow our Supreme Court's direction to address whether there were any circumstances under which Mary Hegadorn could receive the Hegadorn SBO Trust principal. On review, the circuit court answered this question, but misapplied the law to the facts of this case. We therefore affirm the circuit court in part, reverse in part, and remand to the ALJ for further proceedings.

I. BACKGROUND

This case has a long procedural history and this is the second time this case is before this Court. See *Hegadorn v Dep't of Human Servs. Dir.*, 320 Mich App 549, 555, 904 N.W.2d 904 (2017) (*Hegadorn I*), rev'd*Hegadorn vDep't of Human Servs. Dir.*, 503 Mich. 231, 931 N.W.2d 571 (2019) (*Hegadorn II*). The issues in this case turn on the terms of two documents: the Hegadorn SBO Trust and the Special Supplemental Care Trust for Mary Ann Hegadorn (Supplemental Care Trust).

A. HEGADORN APPLIES FOR MEDICAID BENEFITS

On December 20, 2013, Mrs. Hegadorn, an "institutionalized spouse"[2] under the Medicaid program, began receiving long-term care at a nursing home in Howell, Michigan. To be eligible to receive Medicaid long-term benefits to pay for her care, Mrs. Hegadorn's countable assets could not exceed $2,000. To meet this threshold, on January 23, 2014, Mr. Hegadorn, a "community spouse,"[3] established and funded the Hegadorn SBO Trust. Mr. Hegadorn was the trust beneficiary for the Hegadorn SBO Trust. Neither he nor his wife was the trustee or successor trustee. As our Supreme Court observed in *Hegadorn II*, "Section 2.2. of the Hegadorn Trust states that 'Trustee shall distribute the Resources of the Trust at a rate that is calculated to use up all of the Resources during' Mr. Hegadorn's expected lifetime, and it includes a suggested distribution schedule that is based on the [MDHHS's] policies." *Hegadorn II*, 503 Mich. at 240-241, 931 N.W.2d 571. The Hegadorn SBO Trust also lists another trust as a possible residual beneficiary, stating:

> ***2** At my death, if my Spouse is surviving, Trustee shall distribute the remaining trust property to the trustee of the Special Supplemental Care Trust for Mary Ann Hegadorn, created by my Will dated the same day as this Agreement, as my Will may be amended from time to time. [*Id.*, quoting Hegadorn Trust, § 3.3 (formatting altered in *Hegadorn II*, 503 Mich. at 240-241, 931 N.W.2d 571).]

In other words, Mrs. Hegadorn and her husband created the Hegadorn SBO Trust to make her eligible for Medicaid long-term care benefits, and designed it in a way that contemplated Mr. Hegadorn using the trust assets during his life. In the event that he died first, the Hegadorn SBO Trust would fund a new trust, the Supplemental Care Trust. As described below, over this case's procedural history, the administrative apparatus and courts have scrutinized the terms of the Hegadorn SBO Trust. The Supplemental Care Trust, however, does not appear to be part of the record and its terms are unknown.

On April 24, 2014, Mrs. Hegadorn applied for Medicaid benefits to pay for her long-term care. MDHHS denied her application, determining that the assets in the Hegadorn SBO Trust were countable assets, and her countable assets exceeded the applicable financial eligibility limit, known as the community spouse resource allowance (CSRA).[4]

B. HEGADORN APPEALS DENIAL TO ADMINISTRATIVE LAW JUDGE

Mrs. Hegadorn appealed, and following an administrative hearing, the ALJ upheld MDHHS's decision. The ALJ concluded that Mrs. Hegadorn and her husband's combined assets were $487,755.33 when she entered the nursing home on December 20, 2013. *Hegadorn I*, 320 Mich App at 555, 904 N.W.2d 904. The CSRA was fixed at $115,920, leaving countable assets totaling $371,835.33, which would disqualify Mrs. Hegadorn from Medicaid eligibility. *Id.* at 555-556, 904 N.W.2d 904. Regarding these calculations, the ALJ explained that a person's countable assets include "the value of the trust's countable income if there is any condition under which the income could be paid to or on behalf of the person." *Id.* at 556, 904 N.W.2d 904 (quotation marks omitted). And because the Hegadorn SBO Trust required that the trust principal be distributed to Hegadorn's husband during his lifetime, the ALJ concluded that those assets "could be paid to or on behalf of the person," and therefore were countable toward the CSRA. *Id.* Essentially, the ALJ concluded that a trust payment to Hegadorn's husband was effectively a payment for her benefit because of the nature of marriage.

C. CIRCUIT COURT REVERSES ALJ

***3** Mrs. Hegadorn appealed to the Livingston County Circuit Court, which reversed the ALJ's decision and ordered Medicaid benefits to begin as of the date she applied for benefits. *Hegadorn I*, 320 Mich App at 559, 904 N.W.2d 904. The circuit court relied on a MDHHS memorandum from July 2014 to conclude that MDHHS had changed its policy after the trust was established in 2014. See *id.* at 559, 565, 904 N.W.2d 904 (noting the circuit court's reliance on *Hughes v McCarthy*, 734 F.3d 473 (CA 6, 2013) and Michigan Department of Human Services, *Bridges Eligibility Manual (BEM) 401*, 2014-015 (July 1, 2014), p. 11). After the memorandum (*BEM 401*), all SBO trust assets were deemed countable, but the circuit court concluded that trusts established before the memorandum were not countable. *Id.* at 559, 904 N.W.2d 904. The circuit court therefore concluded that the Hegadorn SBO Trust assets were not countable.

D. *HEGADORN I*: COURT OF APPEALS REVERSES CIRCUIT COURT

This Court granted MDHHS's application for leave to appeal and consolidated the case with *Lollar v Dep't of Human Servs Dir* and *Ford v Dep't of Health and Human Servs*, both of which also involved the denial of Medicaid benefits to pay for the long-term care of applicants whose husbands had created SBO trusts. *Hegadorn II*, 503 Mich. at 238, 931 N.W.2d 571; *Hegadorn I*, 320 Mich App at 549, 904 N.W.2d 904. In *Hegadorn I*, this Court upheld the denial in all three decisions, reasoning that the critical issue was whether there was any condition under which the principal of the irrevocable trusts could be paid to or on behalf of the person from an irrevocable trust. *Hegadorn I*, 320 Mich App at 561, 904 N.W.2d 904, citing *BEM 401*. After considering the language of the trusts, which were largely identical as it related to distributions to each husband "or for my sole benefit, during my lifetime," in "an actuarially sound basis," the Court concluded that the trust assets were countable. *Id.* at 563, 904 N.W.2d 904. Relying on *BEM 401* and *BEM 405*, it concluded that the trusts, though designed to be used up by the spouses during their lifetimes, still included a condition under which the principal could be paid to or on behalf of the person from an irrevocable trust," and MDHHS therefore properly determined the assets to be countable. *Id.* at 563, 904 N.W.2d 904, citing Michigan Department of Human Services, *BEM 405*, BPB 2015-0'0 (July 1, 2015), p. 12, and *BEM 401*, p. 12.

E. *HEGADORN II*: SUPREME COURT REVERSES COURT OF APPEALS AND ALJ

Our Supreme Court reversed, finding that both the ALJ and this Court misread the operative statute, 42 USC 1396p(d). *Hegadorn II*, 503 Mich. at 268-269, 931 N.W.2d 571. The Court held that the principal of an irrevocable trust formed solely for the benefit of a community spouse (like the Hegadorn SBO Trust) "is not per se a 'resource available' to an institutionalized spouse under 42 USC 1396r-5(c)(2) for the purpose of determining an institutionalized spouse's eligibility for Medicaid benefits." *Hegadorn II*, 503 Mich. at 264-265, 931 N.W.2d 571.

In reaching its conclusion, the Supreme Court first summarized the two computations required under 42 USC 1396r-5 (providing the treatment of income and resources for institutionalized spouses) to determine whether an institutionalized spouse is eligible for Medicaid benefits: first, the total joint resources during the first continuous period of institutionalization; and second, the resources available to the institutionalized spouse on the date of the application for Medicaid benefits. *Hegadorn II*, 503 Mich. at 250-254, 263-265, 931 N.W.2d 571. The "any-circumstances" inquiry at issue in this case is a component of the second computation. See *Hegadorn II*, 503 Mich. at 262-263, 931 N.W.2d 571.

The first computation determines the total joint resources of the institutionalized spouse and the community spouse " ' 'as of the beginning of the first continuous period of institutionalization,' which may or may not be the same month in which one applies for benefits.' " *Hegadorn II*, 503 Mich. at 250-251, 931 N.W.2d 571, quoting 42 USC 1396r-5(c)(1)(A). MDHHS makes this computation in order to determine the CSRA:

> ***4** One-half of the total value of their countable resources "to the extent either the institutionalized spouse or the community spouse has an ownership interest" is considered a spousal share.
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> "The spousal share allocated to the community spouse qualifies as the ... CSRA, subject to a ceiling ... indexed for inflation" by Congress. The CSRA is the monetary value of assets that may be retained by or transferred to the community spouse without those resources being counted against the institutionalized spouse for his or her initial eligibility determination. Available resources in excess of the CSRA will generally disqualify an institutionalized

> spouse from receiving Medicaid benefits unless they are spent down prior to filing an application. [*Id.* at 251, 931 N.W.2d 571 (citations omitted).]

The second computation identifies "the resources available to the institutionalized spouse" as of the day they submit the application for Medicaid benefits. *Hegadorn II*, 503 Mich. at 251-252, 931 N.W.2d 571. The agency makes this computation to determine "the institutionalized spouse's initial Medicaid eligibility." *Id.* at 251, 931 N.W.2d 571. " 'In determining the resources of an institutionalized spouse at the time of application for benefits ..., all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse' to the extent that they exceed the CSRA." *Id.* at 252, 931 N.W.2d 571, quoting 42 USC 1396r-5(c)(2)(A) and (B) (emphasis omitted).

The Court explained that the resource allocation provisions of the Medicare Catastrophic Coverage Act, 42 USC 1396r-5, "are silent with regard to the treatment of assets held by a trust." *Hegadorn II*, 503 Mich. at 252, 931 N.W.2d 571. It noted that, as a general legal principle, an irrevocable trust's principal is not available to either the institutionalized spouse or the community spouse because it is held by the trustee. *Id.* at 253-254, 931 N.W.2d 571. But the Court observed, under the Medicaid trust rules, specifically 42 USC 1396p(d), the principal may still be viewed as available to the institutionalized spouse. *Id.* at 254, 931 N.W.2d 571.

Hegadorn II summarized the situations in which a trust resource would be "available" to an institutionalized spouse, as situations satisfying the three criteria under 42 USC 1396p(d):

> [T]he principal of an irrevocable trust formed solely for the benefit of a community spouse is not per se a "resource available" to an institutionalized spouse under 42 USC 1396r-5(c)(2) for the purpose of determining an institutionalized spouse's eligibility for Medicaid benefits. Assets making up the principal of such a trust are not automatically considered countable assets for Medicaid eligibility determinations. However, the principal of an irrevocable trust may become a resource available to an institutionalized spouse, and thus a countable asset, if the following conditions are met: (1) assets of the institutionalized spouse are used to form the principal of the trust, 42 USC 1396p(d)(2)(A); (2) the institutionalized spouse, his or her spouse, or one of the other entities listed under 42 USC 1396p(d)(2)(A)(i) through (iv) established the trust using a means other than a will; and (3) there are "any circumstances under which payment from the trust could be made to or for the benefit of" the institutionalized spouse, 42 USC 1396p(d)(3)(B)(i). [*Hegadorn II*, 503 Mich. at 264-265, 931 N.W.2d 571 (emphasis omitted).]

***5** In other words, the trust principal counts if (1) the institutionalized spouse's assets form the principal, (2) the institutionalized spouse (or their spouse or an entity listed in 42 USC 1396p(d)(2)(A)(i) through (iv)) created the trust through means other than a will,[5] and (3) there are any circumstances under which payment from the trust could be made for the benefit of the institutionalized spouse. See *id.* To make this determination, the Court explained, the agency, ALJ, or court, must examine the language of the trust documents. *Id.* at 265, 931 N.W.2d 571.

Hegadorn II concluded that the first two prongs of this three-prong test were satisfied. *Hegadorn II*, 503 Mich. at 265-266, 931 N.W.2d 571. Mrs. Hegadorn's assets formed the Hegadorn SBO Trust principal, and her husband created the Hegadorn SBO Trust through means other than a will. *Id.* at 265-269, 931 N.W.2d 571.

Regarding the third prong, what the Court described as the "any-circumstances rule," *Hegadorn II* concluded that the ALJ and Court of Appeals' analysis and conclusions relied on a misreading of the federal statutes. *Hegadorn II*, 503 Mich. at 268-269, 931 N.W.2d 571. The Court therefore vacated the final administrative decision and reversed this Court's prior decision. *Id.* at 269, 931 N.W.2d 571. But, acknowledging the complexity of Medicaid and MDHHS's concerns regarding abuse, the Supreme Court declined to rule on whether the third prong was satisfied. *Id.* Instead it remanded to the ALJ, who "may have forgone consideration of alternative avenues of legal analysis." *Id.* at 269, 931 N.W.2d 571. It remanded the case to the ALJ for additional administrative hearings consistent with its opinion, including determining whether there were any circumstances under which the principal of the Hegadorn SBO Trust could be paid for Mrs. Hegadorn's benefit. *Id.* at 269-270, 931 N.W.2d 571.

F. ADMINISTRATIVE DECISION ON REMAND

On remand, the ALJ again affirmed the denial of Mrs. Hegadorn's Medicaid application. In doing so, the ALJ cited sections 2.2 and 3.3 of the Hegadorn SBO Trust:

> 2.2 *Distribution of Resources.* During each fiscal year of the Trust, Trustee shall from time to time during the fiscal year pay or distribute to me, or for my sole benefit, during my lifetime such part of all of the net income and principal ("Resources") of the Trust as Trustee determines is necessary in order to distribute the resources in an actuarilly sound basis....
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> * * *
>
> 3.3 *Distribution if Spouse Survives.* At my death, if my Spouse is surviving, Trustee shall distribute the remaining trust property to the trustee of the Special Supplemental Care Trust for Mary Ann Hegadorn, created by my Will dated the same day as this Agreement, as my Will may be amended from time to time. [Hegadorn SBO Trust, §§ 2.2 and 3.3 (formatting altered).]

Relying on these provisions, the ALJ concluded that all the trust assets were countable, explaining that because "all assets are expected to be paid to [Mary Ann's] spouse[,] ... there are conditions under which the principal could be paid to or on behalf of [Mary Ann] ...." In sum, the ALJ concluded that the any-circumstances rule had been satisfied, explaining:

> ***6** The Trustee was advised to distribute all the assets on an actuarially sound basis, which for Medicaid purposes means that it must be returned to Petitioner's spouse over his lifetime. BEM, Item 405 pages 11-12. The "available" standard used for assets does not apply to trusts. BEM, Item 400, page 12. Thus, even if the trust had limitations on the yearly amounts, all assets are expected to be paid to Petitioner's spouse so there are conditions under which the principal could be paid to or on behalf of the person and all assets are countable. BEM, Item 401, page 11. If the principal of the trust can be paid to the spouse at some time in the future, *and spouses are responsible for one another*, the condition, however remote, does exist. [Emphasis added.]

Notably, except for the last sentence of the above quoted language, this portion of the ALJ's decision is a verbatim reiteration of a passage included in its earlier 2014 decision. In other words, because Mr. Hegadorn would receive payments from the trust, and spouses are responsible for each other, a payment to Mr. Hegadorn satisfied the any-circumstances rule.

The ALJ also concluded that the Hegadorn SBO Trust was not in "effect until after the initial assessment, which is the determinative factor for what assets are countable for purposes of [the] Medical Assistance eligibility determination"; therefore, Mrs. Hegadorn "retained in excess of $2000 in countable, available assets, which must be counted for purposes of Medical Assistance benefit eligibility ...." This statement related to the first of the two calculations identified in *Hegadorn II*: the total joint resources during the first continuous period of institutionalization. The ALJ ended her analysis there without addressing the separate calculation related to the resources available to the institutionalized spouse the day of the application for Medicaid benefits. See *Hegadorn II*, 503 Mich. at 250-252, 931 N.W.2d 571. As stated above, that day was after the creation of the Hegadorn SBO Trust.

G. CIRCUIT COURT'S REVIEW OF ALJ DECISION ON REMAND

Mr. Hegadorn appealed to the circuit court, and the circuit court reversed the ALJ's decision on remand and ordered MDHHS to approve Mrs. Hegadorn's application for Medicaid benefits. The circuit court noted that the Hegadorn SBO Trust did not provide payment to the institutionalized spouse even in the event of Mr. Hegadorn's death. Rather, the trust language provided that the residual assets would be transferred to a testamentary trust, which, the circuit court concluded, are specifically exempted from the "any-circumstances test" under 42 USC 1396p(d)(3)(B). In its written order, the circuit court made eight explicit findings including four relevant to this appeal:

> 5. [The] Administrative Law Judge decision was affected by a substantial and material error of law, to wit: The ALJ ... did not adhere to the findings by the Michigan Supreme Court, and erroneously determined that the [Hegadorn SBO Trust] was "countable" to Mary Ann Hegadorn (the "institutionalized spouse") because it

could make future payments to Ralph D. Hegadorn (Mary Ann's husband).

6. A trust created by Will is excluded from the "any circumstances" rule of 42 USC 1396p(d)(3)(B)[.]

7. A distribution from the [Hegadorn SBO Trust] to a trust created under Ralph D. Hegadorn's Will (or to the trustee of such a trust) is not a payment from that Sole Benefit Trust to or for the benefit of Mary Ann Hegadorn from the [Hegadorn SBO Trust].

8. No circumstances exist under which payments *from* the [Hegadorn SBO Trust] could be made to or for the benefit of Mary Ann Hegadorn .... [Formatting altered.]

MDHHS moved for reconsideration, and the circuit court denied the motion. This appeal followed.

H. THE SUPPLEMENTAL CARE TRUST

***7** Despite this case's extensive history, our review of the record indicates that a document critical to the ALJ's analysis is not part of the record. As stated, the Hegadorn SBO Trust contains a contingency if Mr. Hegadorn predeceased Mrs. Hegadorn. The trust assets, through the function of Mr. Hegadorn's will, would fund the Supplemental Care Trust. Although this instrument is referenced throughout the record, the document itself and its terms are not part of the record.

II. STANDARD OF REVIEW

This case involves the circuit court's review of an administrative decision. The Michigan Constitution provides that all final decisions of any administrative officer or agency which are judicial or quasi-judicial and affect private rights are subject to direct review by the courts as provided by law. See Const. 1963, art. 6, § 28. "This review shall include, as a minimum, the determination whether such final decisions ... are authorized by law ...." *Id.*

Under the Administrative Procedures Act, MCL 24.201 *et seq.*, unless the law provides a different scope of review, a court may set aside an administrative decision if it violates the constitution or a statute, see MCL 24.306(1)(a), or if the decision is "[a]ffected by other substantial and material error of law," MCL 24.306(1)(f).

We review de novo issues of statutory interpretation. *Hegadorn II*, 503 Mich. at 244-245, 931 N.W.2d 571. We likewise review de novo construction of the language of a trust document. *Id.* at 245, 931 N.W.2d 571.

III. LAW AND ANALYSIS

The circuit court correctly determined that the ALJ erred when it concluded that Ralph Hegadorn's entitlement to benefits under the Hegadorn SBO Trust on its own constituted a circumstance under which Mary Ann Hegadorn might benefit from that trust. It nonetheless erred when it concluded that the Hegadorn SBO Trust funding the Supplemental Care Trust did not constitute a circumstance under which a payment was made for the benefit of Mary Ann Hegadorn. To make this determination the reviewing tribunal would need to review the terms of the Supplemental Care Trust, which is not part of this record.

A. THE CIRCUIT COURT CORRECTLY REVERSED THE ALJ'S APPLICATION OF THE "ANY-CIRCUMSTANCES TEST"

The circuit court correctly concluded that the ALJ misapplied the law as directed by our Supreme Court in *Hegadorn II*. The ALJ made two critical errors. First, like its original review of MDHHS's denial, the ALJ treated Mr. Hegadorn and Mrs. Hegadorn as alter egos to reach the conclusion that a payment from the Hegadorn SBO Trust to Mr. Hegadorn was essentially for Mrs. Hegadorn's benefit. Our Supreme Court explicitly rejected this analysis. *Hegadorn II*, 503 Mich. at 239, 931 N.W.2d 571. Second, the ALJ appears to have relied on only the first of the two required computations for determining Medicaid eligibility. See *id.* at 250-252, 931 N.W.2d 571.

The ALJ's first error was her reliance on the general customary expectation that "spouses are responsible for one another" to reach the legal conclusion that payments from the Hegadorn SBO Trust to Mr. Hegadorn constituted a circumstance, "however remote," under which Mrs. Hegadorn might receive benefit from the trust principal. This reflected a failure to appreciate that spouses retain avenues for obtaining and maintaining separate property, and that the law related to Medicaid eligibility, and estate planning, might and does reflect that.

In *Hegadorn II*, our Supreme Court explicitly rejected this reasoning. It specifically held that a trust's payments to "a community spouse does not automatically render the assets held by the trust countable for the purpose of an institutionalized spouse's initial eligibility determination." *Hegadorn II*, 503 Mich. at 239, 931 N.W.2d 571. In reaching this conclusion, the Court in *Hegadorn II* rejected federal caselaw that rested on the presumption that trust proceeds benefiting one spouse automatically benefit the other. See *Hegadorn II*, 503 Mich. at 268 & n 26, 931 N.W.2d 571 (rejecting the holding in *Johnson v Guhl*, 357 F.3d 403, 409 (3rd Cir. 2004)). In *Johnson v Guhl*, the United States Court of Appeals for the Third Circuit held that the any-circumstances test is satisfied if nothing in the pertinent irrevocable trust specifically prevented the community spouse from sharing payments from it with the institutionalized spouse. *Johnson*, 357 F.3d at 409. *Hegadorn II* disagreed:

> ***8** While the Third Circuit appears to agree that "the individual" refers to an applicant for or recipient of Medicaid benefits, its conclusory analysis disregards the statutory language requiring that the payment be a "payment *from the trust*" that "could be made *to or for the benefit of the individual.*" 42 USC 1396p(d)(3)(B)(i) (emphasis added). The Third Circuit's broad language also effectively reads away any difference in the language used in the § 1396p(d)(3) any-circumstances rule and the § 1382b(e) any-circumstances rule. [*Hegadorn II*, 503 Mich. at 268 n 26, 931 N.W.2d 571, citing *Johnson*, 357 F.3d at 408-409.]

The ALJ therefore erred in concluding that a payment from the Hegadorn SBO Trust to Mr. Hegadorn was effectively for Mrs. Hegadorn's benefit.

The ALJ also erred when it treated as dispositive the fact that the Hegadorn SBO Trust was not in "effect until after the initial assessment, which is the determinative factor for what assets are countable for purposes of [the] Medical Assistance eligibility determination." This led to the conclusion that Mrs. Hegadorn still possessed the assets that funded the Hegadorn SBO Trust and therefore "retained in excess of $2000 in countable, available assets, which must be counted for purposes of Medical Assistance benefit eligibility." This also led the ALJ to end her analysis there. Instead, the ALJ should have addressed the separate calculation regarding resources available as of the day the institutionalized spouse applied for Medicaid benefits. See *Hegadorn II*, 503 Mich. at 250-252, 931 N.W.2d 571. Here, that date was April 24, 2014, after Mr. Hegadorn established the Hegadorn SBO Trust.

Again, the Supreme Court has held that the principal of an irrevocable trust is properly considered a resource available to an institutionalized spouse if "(1) assets of the institutionalized spouse are used to form the principal of the trust; (2) the institutionalized spouse, his or her spouse, or one of the other [statutorily listed] entities established the trust using a means other than a will; and (3) there are 'any circumstances under which payment from the trust could be made to or for the benefit of' the institutionalized spouse." *Hegadorn II*, 503 Mich. at 264-265, 931 N.W.2d 571, citing 42 USC 1396p(d)(2)(A), and quoting 42 USC 1396p(d)(3)(B)(i). With respect to the Hegadorn SBO Trust and Mary Ann Hegadorn, only the third of these factors is at issue. *Hegadorn II*, 503 Mich. at 265-266, 931 N.W.2d 571.

The ALJ's two errors in following our Supreme Court's mandate in *Hegadorn II* prevented her from fully addressing this question: are there any circumstances under which a payment from the trust could be made for the benefit of Mary Ann Hegadorn? Its conclusion ignored the three-prong analysis that *Hegadorn II* explained as necessary under 42 USC 1396p(d) to determine whether the principal of an SBO trust "may become a resource to an institutionalized spouse, and thus a countable asset[.]" *Hegadorn II*, 503 Mich. at 264-265, 931 N.W.2d 571.

B. THE CIRCUIT COURT ERRED BY APPLYING 42 USC 1396P(D)(2)(A)

The circuit court attempted to answer this question, but it reached the wrong conclusion. Although the circuit court correctly concluded that the ALJ erred in applying the law from *Hegadorn II* to the facts of this case, specifically the trust documents, the circuit court erred in concluding that the Supplemental Care Trust, the trust contemplated to be funded by the Hegadorn SBO Trust if Mr. Hegadorn had predeceased Mrs. Hegadorn, could not satisfy the any-circumstances test because it was created by a will.

***9** The circuit court quickly and correctly resolved the question of whether a payment from the Hegadorn SBO Trust to Mr. Hegadorn was effectively a payment to Mrs. Hegadorn. (As stated, it was not.) It then focused the bulk of its any-circumstances analysis on provisions within the Hegadorn SBO Trust that would fund the Supplemental Care Trust for Mrs. Hegadorn in the event that she survived Mr. Hegadorn. It observed that, in the event that the Hegadorn SBO Trust

still had assets upon the death of its sole beneficiary, Ralph Hegadorn, "the residual is transferred to a testamentary trust." Relying on 42 USC 1396p(d)(3)(B), the circuit court concluded that these types of trusts are specifically exempt from the any-circumstance test. This was incorrect.

What our Supreme Court has called the "any-circumstances rule" flows from the language of 42 USC 1396p(d), which provides, in relevant part:

> (1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, ... the rules specified in paragraph (3) shall apply to a trust established by such individual.
>
> (2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:
>
> (i) The individual.
>
> (ii) The individual's spouse.
>
> * * *
>
> [(3)](B) In the case of an irrevocable trust—
>
> (i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—
>
> (I) to or for the benefit of the individual, shall be considered income of the individual, and
>
> (II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c)[.]

Application of the any-circumstances rule requires a court or administrator to "consider not only obvious circumstances, but also those that are hypothetical or even unlikely." *Hegadorn II*, 503 Mich. at 258, 931 N.W.2d 571. The fact that the Hegadorn SBO Trust assets might one day fund the Supplemental Care Trust, which is for Mary Hegadorn's benefit, very well may satisfy the any-circumstances test depending on the terms of the Supplemental Care Trust. The circuit court avoided addressing this issue by relying on the fact that the Supplemental Care Trust is created by a will, and therefore, according to the circuit court, excluded from the any-circumstance test.

This relied on a misreading of the statute. 42 USC 1396p(d)(2)(A) does not provide that a trust created by a will may never be considered a resource benefiting an institutionalized Medicaid applicant. See 42 USC 1396p(d)(2)(A). It only provides that a Medicaid applicant is viewed as establishing a trust if the applicant's assets formed at least part of the trust corpus, and the applicant (or certain others, including their spouse) "established such trust other than by a will." Therefore, if the institutionalized spouse did not establish the trust under subsection (d)(2)(A), then, under 42 USC 1396p(d)(1), the rules provided in 42 USC 1396p(d)(3), including the any-circumstances rule, do not apply. To summarize and simplify, subsection (d)(1) says the rules in (d)(3) only apply to a trust created by an individual. Subsection (d)(2) defines which trusts are deemed to have been created by the individual, and trusts made by wills do not count.

A will created the Supplemental Care Trust, but Hegadorn and her spouse created the Hegadorn SBO Trust. The question, therefore, is not whether there was any circumstance under which the Supplemental Care Trust would make payment for her benefit. Rather, the question is whether the Supplemental Care Trust, through its creation, funding, and terms, amounted to a circumstance under which the Hegadorn SBO Trust is making a payment for her benefit.

***10** The Hegadorns established the Hegadorn SBO Trust in part with Mary Hegadorn's assets and not through function of a will; therefore, the agency and the court had to apply the any-circumstances test. The circuit court correctly concluded that the Hegadorn SBO Trust providing benefits to Mary Ann Hegadorn's spouse, Ralph, was not itself a circumstance that amounted to benefits to Mary Ann. It also correctly focused its inquiry on whether the Supplemental Care Trust satisfied the any-circumstances test. It just never answered the question because it misapplied 42 USC 1396p(d).

We are unaware of, and the parties have not identified, a requirement in the rules or statute that when assets of the SBO trust transfer to another trust, the second trust must also comply with 42 USC 1396p(d)(2). The public policy underlying the omission of such a rule is obvious: if such a requirement existed, the unscrupulous could circumvent Medicaid rules by laundering assets through a shell-game of various irrevocable trusts. Then congressional "efforts

to prevent spousal pauperization while at the same time limiting the ability of wealthier individuals to shelter income and assets using estate planning rules" would be undone. *Hegadorn II*, 503 Mich. at 249, 931 N.W.2d 571.

C. THE MISSING TRUST DOCUMENT

The circuit court's error reveals a broader problem with the ALJ and MDHHS's analysis: the terms of the Supplemental Care Trust are unknown. To our knowledge, the record does not contain a copy of the "Special Supplemental Care Trust for Mary Ann Hegadorn" that the Hegadorn SBO Trust references in Section 3.3. Although the ALJ and circuit court both referenced Section 3.3., neither tribunal, nor the parties have addressed the particulars of the Supplemental Care Trust's terms, such as whether Mary Ann would have held title to the trust assets, be entitled to direct payments, or if the trustee's discretion regarding distributions were otherwise limited. In the context of other types of public assistance, settlors may design trusts with limitations so as not to exclude eligibility for public assistance. See, e.g., Social Security Program Operations Manual System (POMS) SI 01120.200B.12 (providing that a special needs trust beneficiary may be eligible to receive public assistance benefits), available at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200> (accessed September 29, 2023); [6] POMS SI § 01120.200B.13 (describing "spendthrift clauses" which limit a beneficiary's access to trust assets, so that trust assets and payments are not countable as a resource). [7] See also POMS SI § 01120.200B.1 (discretionary trusts). [8] It remains unknown if the Supplemental Care Trust contains such limiting provisions. But it is undisputed that the purpose of the trust is to provide support for Mrs. Hegadorn. *Hegadorn II* instructs that when applying the any-circumstances rule, this Court should "consider not only obvious circumstances, but also those that are hypothetical or even unlikely." *Hegadorn II*, 503 Mich. at 258, 931 N.W.2d 571. At the same time, this Court must consider the language of the trust document. *Id.* at 265, 931 N.W.2d 571. On this record, these two mandates conflict. On its plain terms, Section 3.3 of the Hegadorn SBO Trust contemplates a circumstance under which a payment is made for the benefit of Mary Ann Hegadorn. The nature of that benefit and whether the Supplemental Care Trust is countable is unknowable without the document.

***11** Acknowledging the nuanced calculations required to determine Medicaid eligibility, our Supreme Court remanded this case to the ALJ on the understanding that it dispensed with these calculations due to a legal error. On remand, the ALJ again dispensed with the calculations due to a second closely-related legal error. We now remand to the ALJ a third time, with an even more limited mandate: to review the terms of the Supplemental Care Trust, determine whether under its terms its assets would have been countable in determining Mary Ann Hegadorn's Medicaid eligibility, and to apply the any-circumstances test and calculations described in *Hegadorn II*.

IV. CONCLUSION

For the reasons stated above, we affirm the circuit court's decision reversing the ALJ decision for misapplying *Hegadorn II* to the facts of this case. We reverse the circuit court's decision to the extent its conclusions relied on a misapplication of 42 USC 1396p(d). We remand to the ALJ for further proceedings consistent with this opinion. Specifically, the ALJ is directed to obtain the Supplemental Care Trust, review its terms, and apply the principles of *Hegadorn II* to the facts of this case. We do not retain jurisdiction.

All Citations

--- N.W.3d ----, 2023 WL 6931925

Footnotes

1 *Hegadorn Estate v Livingston Cty Dep't of Health & Human Servs*, unpublished order of the Court of Appeals, entered August 17, 2021 (Docket No. 356756).

2 "An 'institutionalized spouse' is a person who is in a 'medical institution or nursing facility' or who is described in 42 USC 1396a(a)(10)(A)(*ii*)(VI), is likely to meet these requirements 'for at least 30 consecutive days,' and

is married to a person who is not in such a facility." *Hegadorn II*, 503 Mich. at 237 n 2, 931 N.W.2d 571, citing 42 USC 1396r-5(h)(1)(A) and (B).

3 "A 'community spouse' is 'the spouse of an institutionalized spouse.' " *Hegadorn II*, 503 Mich. at 238 n 3, 931 N.W.2d 571.

4 "The spousal share allocated to the community spouse qualifies as the [community spouse resource allowance or] CSRA, subject to a ceiling ... indexed for inflation' by Congress." *Hegadorn II*, 503 Mich. at 251, 931 N.W.2d 571, quoting *Wisconsin Dep't of Health and Family Servs. v Blumer*, 534 U.S. 473, 482, 122 S Ct 962, 151 L Ed 2d 935 (2002). The CSRA is the maximum value of assets that a community spouse can retain (or that can be transferred to the community spouse) without MDHHS counting those resources against the institutionalized spouse or her initial eligibility determination. *Hegadorn II*, 503 Mich. at 251, 931 N.W.2d 571, citing 42 USC 1396r-5(c)(2)(B) and (f); *Blumer*, 534 U.S. at 482-483, 122 S.Ct. 962. If resources exceed the CSRA, an institutionalized spouse will generally be disqualified from receiving Medicaid benefits unless they are spent down prior to filing an application. *Hegadorn II*, 503 Mich. at 251, 931 N.W.2d 571, citing 42 USC 1396r-5(c)(2); *Blumer*, 534 U.S. at 482-483, 122 S.Ct. 962.

5 The Court in *Hegadorn II* also concluded that MDHHS and this Court erred when they determined that the "individual" identified in 42 USC 1396p(d) can be the institutionalized spouse, the community spouse, or the two in combination. *Hegadorn II*, 503 Mich. at 259, 931 N.W.2d 571. The "individual" referred to in the trust rules "is the institutionalized spouse, who is the Medicaid applicant." *Id.* at 255, 931 N.W.2d 571. The Supreme Court concluded that the test of 42 USC 1396p(d)(3)(B) foreclosed any contrary administrative interpretation or application of *BEM 401*.*Id.* at 266-267, 931 N.W.2d 571.

6 POMS SI § 01120.200B.12 provides:

> A special needs trust, also known as a supplemental needs trust, may be set up to provide for a disabled individual's extra and supplemental needs other than food, shelter, and health care expenses that may be covered by public assistance benefits that the trust beneficiary may be eligible to receive under various programs.

7 POMS SI § 01120.200B.13 provides in part:

> A spendthrift clause or spendthrift trust generally prohibits both involuntary and voluntary transfers of the trust beneficiary's interest in the trust income or principal. This means that the trust beneficiary's creditors must wait until the trust pays out money to the trust beneficiary before they can attempt to claim it to satisfy debts.
>
> It also means that, for example, if the trust beneficiary is entitled to $100 a month from the trust, the beneficiary cannot sell his or her right to receive the monthly payments to a third party for a lump sum. In other words, a valid spendthrift clause would make the value of the trust beneficiary's right to receive payments not countable as a resource.

8 POMS SI § 01120.200B.1 provides:

> A discretionary trust is a trust in which the trustee has full discretion as to the time, purpose, and amount of all distributions. The trustee may pay all or none of the trust as he or she considers appropriate to, or for the benefit of, the trust beneficiary. The trust beneficiary has no control over the trust.

2024 WL 2754048
United States District Court, W.D. Oklahoma.

Penelope LAMLE, BY AND THROUGH Joshua LAMLE and Lexy Jobe, next friends and attorneys-in-fact; Marilyn Garrison, by and through Devra Boyd, next friend and attorney-in-fact; and Maxine Houston, by and through Dal Houston and Mary Powell, next friends and attorneys-in-fact, Plaintiffs,
v.
Deborah SHROPSHIRE, Director of Oklahoma Department of Human Services, in her official capacity; Susan Eads, individually; and Kevin Corbett, CEO of Oklahoma Health Care Authority, in his official capacity, Defendants.

Case No. CIV-22-00391-JD
|
Signed May 29, 2024

Attorneys and Law Firms

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Daniel J. Card, Department of Human Services, Oklahoma City, OK, for Defendants Susan Eads, Deborah Shropshire.

David William Bryan, Joshua J. Holloway, Oklahoma Health Care Authority, Oklahoma City, OK, for Defendant Kevin Corbett.

ORDER

JODI W. DISHMAN, UNITED STATES DISTRICT JUDGE

***1** Medicaid is a federal program implemented by participating states. *See* 42 U.S.C. § 1396 *et seq.* It was created to provide medical care to people "whose income and resources are insufficient to meet the costs of necessary medical services." *Id.* § 1396–1.

This action is brought by three individuals who, prior to their applications for Medicaid benefits, transferred substantial assets in exchange for promissory notes. After the state agency in charge of administering such benefits inquired about their eligibility, Plaintiffs sued. Now before the Court are three Motions to Dismiss ("Motions") [Doc. Nos. 23, 24, 26] filed by Susan Eads ("Eads"), Deborah Shropshire ("Shropshire"), [1] and Kevin Corbett ("Corbett") (collectively, "Defendants"). They seek dismissal of Penelope Lamle ("Lamle"), Marilyn Garrison ("Garrison"), and Maxine Houston's ("Houston") (collectively, "Plaintiffs") Second Amended Complaint [Doc. No. 20] under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim.

Having considered the Second Amended Complaint and the parties' briefing, and for the reasons stated below, the Court grants the Motions and dismisses the action.

I. BACKGROUND

A. Factual Background

1. Penelope Lamle

Lamle is 79 years old and resides in the Greenbrier Nursing Home in Enid, Oklahoma. [2] She is physically incapable of caring for herself. On August 3, 2021, Lamle transferred assets to Jason Lamle, her son, in exchange for a promissory note equal to $357,000.

Lamle applied for Medicaid benefits on November 24, 2021. After reviewing Lamle's application, the Oklahoma Department of Human Services ("OKDHS") reached out inquiring about further details concerning her promissory note.

OKDHS asked whether: (1) Lamle was in the business of lending money or selling property, (2) the borrower offered collateral to secure the promissory note to Lamle, (3) the borrower did anything with the assets after purchasing them from Lamle, (4) Lamle transferred the promissory note to a trust or similar device, and (5) there had been a pattern of lending and repayment between Lamle and the borrower.

Lamle responded to OKDHS and stated the promissory note complied with 42 U.S.C. § 1396p(c)'s requirements, and that OKDHS was not allowed to ask those questions when making a Medicaid eligibility determination. Eads, Assistant General Counsel for OKDHS, then contacted Lamle and asked the same questions. Lamle refused to answer them. Eads and

Lamle emailed back and forth several times. Each time, Eads requested the answers to the questions and explained that the information was needed so OKDHS could determine if the promissory note was considered a "resource" under the applicable standards. Eads told Lamle that refusal to provide the necessary information "may result in denial of the application for eligibility/benefits." And each time, Lamle refused to answer.

***2** On June 9, 2022, 197 days after Lamle submitted her application, OKDHS denied her application for Medicaid.

2. Marilyn Garrison

Garrison is 82 years old and resides at Hennessey Care Center in Hennessey, Oklahoma. She is physically incapable of caring for herself. On October 12, 2021, Garrison transferred assets to her daughter, Devra Boyd, in exchange for a promissory note equal to $721,000.

Garrison applied for Medicaid benefits on December 6, 2021. After receiving Garrison's application, OKDHS reached out to Garrison and asked her the same questions it asked Lamle. Garrison responded to the requests by explaining the promissory note met the necessary requirements.

Eads, in turn, responded on behalf of OKDHS and again requested the information. Garrison refused. Eads and Garrison emailed each other several times. Each time, Eads requested the answers to the questions explaining that refusal to provide the necessary information "may result in denial of the application for eligibility/benefits." And each time, Garrison refused to answer.

On June 9, 2022, 185 days after Garrison filed her application, OKDHS denied her application for Medicaid.

3. Maxine Houston

Houston is 98 years old and resides at the Share Convalescent Center in Alva, Oklahoma. She is physically incapable of caring for herself. On February 3, 2020, Houston transferred assets to T-Spur Minerals Resources L.L.C. in exchange for a promissory note equal to $270,000.

Houston applied for Medicaid benefits on January 27, 2022. After receiving Houston's application, OKDHS asked her the same questions it asked Lamle and Garrison. Houston did not answer.

On June 8, 2022, 132 days after Houston submitted her application, OKDHS denied her application for Medicaid.

B. Procedural Background

Plaintiffs filed this suit. Although they allege that the questions OKDHS asked them were unnecessary for determining their Medicaid eligibility, Plaintiffs answer the questions in their Second Amended Complaint. [3] Defendants moved to dismiss.

II. LEGAL STANDARDS

"Rule 12(b)(6) dismissal 'is appropriate if the complaint alone is legally insufficient to state a claim.' " *Serna v. Denver Police Dep't*, 58 F.4th 1167, 1169 (10th Cir. 2023) (quoting *Brokers' Choice of Am., Inc. v. NBC Universal, Inc.*, 861 F.3d 1081, 1104–05 (10th Cir. 2017)). In considering a motion to dismiss under Rule 12(b)(6), the inquiry is "whether the complaint contains 'enough facts to state a claim to relief that is plausible on its face.' " *Ridge at Red Hawk, LLC v. Schneider*, 493 F.3d 1174, 1177 (10th Cir. 2007) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)).

***3** Under this standard, the Court accepts "the truth of the plaintiff's well-pleaded factual allegations and view[s] them in the light most favorable to the plaintiff." *Id.* However, "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

The plaintiffs must "nudge[ ] their claims across the line from conceivable to plausible" to survive a motion to dismiss. *Twombly*, 550 U.S. at 570. "Thus, the mere metaphysical possibility that *some* plaintiff could prove *some* set of facts in support of the pleaded claims is insufficient; the complaint must give the court reason to believe that *this* plaintiff has a reasonable likelihood of mustering factual support for *these* claims." *Ridge at Red Hawk*, 493 F.3d at 1177.

III. ANALYSIS

Plaintiffs argue that Defendants violated 42 U.S.C. § 1396a(a)(8) as limited by 42 C.F.R. § 435.907(e) because they requested information that was unnecessary for determining Plaintiffs' Medicaid eligibility. They also contend that Defendants violated 42 U.S.C. § 1396a(a)(8) as defined by

42 C.F.R. § 435.912 because they failed to provide Plaintiffs' Medicaid benefits with reasonable promptness. Plaintiffs bring this action under 42 U.S.C. § 1983.[4]

A. OKDHS did not violate Plaintiffs' rights by asking them questions because the requested information was necessary for OKDHS to determine their Medicaid eligibility.

"Congress created Medicaid 'to provide health care to persons who cannot afford such care.' " *Rose as next friend of Rose v. Brown*, 14 F.4th 1129, 1132 (10th Cir. 2021) (quoting *Morris v. Okla. Dep't of Hum. Servs.*, 685 F.3d 925, 928 (10th Cir. 2012)). To qualify, individuals' resources must equal $2,000 or less. *Id.* Oklahoma is required to "extend Medicaid eligibility at least as far as eligibility for Supplemental Security Income." *Id.* The Court therefore considers the rules for Supplemental Security Income when identifying resources for the purposes of evaluating Medicaid eligibility. *Id.*

The rules use two methods for characterizing resources—the regular method and trust method. *Id.* Under the regular method, an asset is a "resource" "[i]f the individual has the right, authority, or power to liquidate the property," whereas "[t]he trust method creates an exception for trusts and trust-like devices, which count as resources even when they cannot be liquidated." *Id.* at 1132–33 (quoting 20 C.F.R. § 416.1201(a)(1)). When making the determination of whether something is a "resource," the Court defers to the Social Security Administration's Program Operations Manual System ("POMS"). *Id.* at 1134 n.6.

For a promissory note to not be considered a resource, it must be from an informal loan that is bona fide. POMS SI § 1120.220. "An informal loan is a loan between individuals who are not in the business of lending money or providing credit." *Rose*, 14 F.4th at 1135. "An informal loan (oral or written) is bona fide if it meets" these requirements:

***4** 1. Enforceable under State law

2. Loan agreement in effect at time of transaction

3. Acknowledgement of an obligation to repay

4. Plan for repayment

5. Repayment plan must be feasible.

Id. (quoting POMS SI § 1120.220(D)). For feasibility of repayment, POMS instructs those reviewing Medicaid applications "to 'consider the amount of the loan, the individual's resources and income, and the individual's living expenses.' " *Id.* at 1136–37 (quoting POMS SI § 1120.220(D)(5)). However, a reviewing entity's authority to require information from applicants is not absolute. 42 C.F.R. § 435.907(e) states:

> Limits on information.
>
> (1) The agency may only require an applicant to provide the information necessary to make an eligibility determination or for a purpose directly connected to the administration of the State plan.
>
> (2) The agency may request information necessary to determine eligibility for other insurance affordability or benefit programs.

Accordingly, the first issue the Court must consider is whether the questions OKDHS (via Eads) asked Plaintiffs were necessary for making eligibility determinations. The first question, whether Plaintiffs were in the business of lending money or selling property, goes straight to the heart of whether the promissory note was from a loan between individuals who are not in the business of lending money or providing credit. The second question, whether Plaintiffs were provided with collateral, addresses whether repayment of the loan was feasible. If the borrowers provided Plaintiffs with valuable collateral, it supports a finding that the borrowers would be able to repay the loan by either actually paying back the loan or by Plaintiffs selling the collateral to recoup the sum of the loan. Similarly, the third question, asking what was done with the assets, goes to feasibility of repayment. If assets conveyed to the borrowers were invested, saved, sold, etc., this goes towards whether they would have sufficient money to repay the loan. The fourth question, whether the promissory notes had been transferred to a trust or similar device, addresses whether the note should be considered a resource under the trust method for characterizing resources. The fifth question, whether there had been a pattern of lending between the borrowers and Plaintiffs, sheds light on whether the loan was informal—similar to the first question.

All these questions sought information that OKDHS needed to determine whether (1) the regular or trust method should be used to characterize the loan, (2) the loan was informal, and

(3) repayment was feasible. The answers to these questions would have enabled OKDHS to determine the eligibility of Plaintiffs. Because Plaintiffs allege that they refused to provide OKDHS answers to its questions and the Court determines that the information was necessary for OKDHS to make eligibility determinations, [5] Plaintiffs have failed to state a plausible claim for relief. [6]

B. OKDHS did not violate Plaintiffs' rights by not making eligibility determinations within 45 days because Plaintiffs refused to take a required action.

***5** Having determined that OKDHS was allowed to ask the questions it asked Plaintiffs, and in light of Plaintiffs' allegations that they failed to answer the questions at the time, the Court now turns to the issue of whether Plaintiffs' rights were violated by not receiving an eligibility determination within 45 days. Here, they were not.

The law requires promptness in eligibility determinations. 42 U.S.C. § 1396a(a)(8) provides:

> A State plan for medical assistance must ... provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals ....

In other words, the statute requires reasonable promptness to "eligible individuals." Reasonable promptness is further expounded in 42 C.F.R. § 435.912 which, in relevant part, states:

> Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant may not exceed ... [f]orty-five days for all other applicants. The agency must determine eligibility within the standards except in unusual circumstances, for example—
>
> (1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or
>
> (2) When there is an administrative or other emergency beyond the agency's control.

42 C.F.R. § 435.912(c)(3)(ii), (e).

OKDHS asked Plaintiffs questions regarding their application and did not receive the information it needed to determine their eligibility. So, even though Plaintiffs did not receive an eligibility determination within 45 days, it was because they failed to answer OKDHS's questions. Because the Court deems dismissal appropriate as explained above, it does not reach Plaintiffs' remaining claims concerning injunctions and Eads' personal liability.

IV. CONCLUSION

For these reasons, the Court concludes that Plaintiffs have failed to state claims on which relief could be granted. Consequently, the Court GRANTS Eads, Shropshire, and Corbett's Motions to Dismiss [Doc. Nos. 23, 24, 26] and DISMISSES Plaintiffs' Second Amended Complaint [Doc. No. 20] with prejudice. [7]

***6** IT IS SO ORDERED this 29th day of May 2024.

All Citations

Slip Copy, 2024 WL 2754048, Med & Med GD (CCH) P 308,106

Footnotes

1 Shropshire was substituted for Justin Brown, the former Director of Oklahoma Department of Human Services.

2 The Court operates on the basis of the allegations in the Second Amended Complaint and its attached exhibits incorporated by reference. If there have been updates to the status of Plaintiffs, the status of Defendants, or

Plaintiffs' applications for Medicaid benefits that would impact the governing complaint or the issues raised in the briefing on the Motions, the parties have not provided those to the Court during the pendency of this action, other than the substitution of Deborah Shropshire for Justin Brown. *Cf. Estate of Schultz v. Brown*, 846 F. App'x 689 (10th Cir. 2021) (unpublished) (analyzing whether the estate's challenge to the validity of Oklahoma's process for reviewing Medicaid applications was barred by the Eleventh Amendment or on Article III grounds).

3 "Evaluating cases for ripeness allows courts to avoid 'premature adjudication' by refraining from 'entangling themselves in abstract disagreements.' " *United States v. Doe*, 58 F.4th 1148, 1154 (10th Cir. 2023), *cert. denied*, 144 S. Ct. 166 (2023) (quoting *United States v. Wilson*, 244 F.3d 1208, 1213 (10th Cir. 2001)). "In other words, '[a] claim is not ripe for adjudication if it rests upon contingent future events that may not occur as anticipated, or indeed may not occur at all.' " *Id.* at 1155 (quoting *Texas v. United States*, 523 U.S. 296, 300 (1998)). At this stage, it is not the Court's role to determine whether Plaintiffs are eligible for Medicaid. If Plaintiffs supply OKDHS with the information they provided the Court, it is not clear they would still be denied coverage. Since this part of Plaintiffs' claim rests on "contingent future events that may not occur as anticipated," the Court refrains from addressing or deciding the issue.

4 " 'The question whether a cause of action exists is not a question of jurisdiction, and therefore may be assumed without being decided.' " *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1143 (10th Cir. 2006) (quoting *Burks v. Lasker*, 441 U.S. 471, 475–76 & n.5 (1979)). Thus, the Court assumes without deciding that § 1983 gives Plaintiffs a right of action to enforce 42 U.S.C. § 1396a(a)(8). *Okla. Chapter of Am. Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208, 1212 n.1 (10th Cir. 2007) (assuming without deciding that § 1983 provides plaintiffs a right of action to sue under 42 U.S.C. § 1396a(a)(8)).

5 Plaintiffs argue that the information OKDHS sought was unnecessary for determining their Medicaid eligibility. However, without answers to its questions, OKDHS was unable to determine if Plaintiffs met the requirements for a bona fide informal loan. For example, OKDHS could not determine if Plaintiffs were in the business of lending money, which is a requirement under POMS SI § 1120.220(D), if Plaintiffs did not tell it. Thus, the Court concludes the requested information was necessary.

6 Plaintiffs interpret *Rose* as forbidding reviewing entities (such as OKDHS) from asking questions such as whether loans were between family members in the business of lending money. However, this misconstrues the Tenth Circuit's decision. *Rose* addressed whether—in addition to being an informal, bona fide loan—a promissory note must be made in good faith to not qualify as a resource. *Rose* rejected "the nine-factor test set out in *Sable v. Velez*, 437 F. App'x 73 (3d Cir. 2011) (unpublished)" because it "conflict[ed] with the substance of subsection (D) and Tenth Circuit precedent." *Rose*, 14 F.4th at 1136. For example, the *Sable* factor Plaintiffs reference, whether the lender is in the business of lending money, is explicitly accounted for in the text of subsection (D). *See* POMS SI § 1120.220(D) ("An informal loan is a loan between individuals who are not in the business of lending money or providing credit."). Therefore, whether a lender is in the business of lending money is not a factor but a requirement. Regardless of what other factors are present, "an informal loan exists *only* when the lender is 'not in the business of lending money.' " *Rose*, 14 F.4th at 1136 (quoting POMS SI § 1120.220(D)) (emphasis added).

7 Plaintiffs argue that their factual allegations make dismissal inappropriate. However, "if, as a matter of law, the complaint ... is insufficient, a motion to dismiss is proper." *Brokers' Choice of Am., Inc. v. NBC Universal, Inc.*, 861 F.3d 1081, 1100 (10th Cir. 2017) (citation omitted). "If such a dismissal operates on the merits of the complaint, it will also ordinarily be entered with prejudice." *Brereton v. Bountiful City Corp.*, 434 F.3d 1213, 1219 (10th Cir. 2006); *see also* Steven S. Gensler, *1 Federal Rules of Civil Procedure, Rules and Commentary*, Rule 12 cmt. (updated Feb. 2024) (explaining that when "the plaintiff has failed to state a claim upon which relief may be granted, ... courts tend to dismiss with prejudice precisely because the motion reaches the merits of the claim"). By Plaintiffs' own allegations, they did not supply OKDHS with the

information it requested. No fact-finding conducted by the Court could change this reality or make Plaintiffs' claims cognizable. Therefore, Plaintiffs claims are legally insufficient, and they have failed "to state a claim for which relief may be granted.' " *Smith v. United States*, 561 F.3d 1090, 1098 (10th Cir. 2009) (quoting *Sutton v. Utah State Sch. for Deaf & Blind*, 173 F.3d 1226, 1236 (10th Cir. 1999)).

This, however, does not prevent Plaintiffs from suing should they reapply for Medicaid and subsequently be denied after providing OKDHS with all the necessary information. This Circuit uses the "transactional test" to determine if causes of action are "identical" for purposes of claim preclusion. *Hatch v. Boulder Town Council*, 471 F.3d 1142, 1149 (10th Cir. 2006). " 'The transactional approach provides that a claim arising out of the same transaction, or series of connected transactions as a previous suit, which concluded in a valid and final judgment, will be precluded.' " *Id.* (quoting *Yapp v. Excel Corp.*, 186 F.3d 1222, 1227 (10th Cir. 1999) (quotations omitted)). However, "[w]here the facts that have accumulated after the first action are enough on their own to sustain the second action, the new facts clearly constitute a new 'claim,' and the second action is not barred by res judicata." *Id.* at 1150 (citation and emphasis omitted). Similarly, as the Court makes no determination regarding whether Plaintiffs are eligible for Medicaid benefits, issue preclusion would not bar Plaintiffs from litigating this issue (based on new facts) later on. *See Park Lake Res. Ltd. Liab. Co. v. U.S. Dep't of Agric.*, 378 F.3d 1132, 1136 (10th Cir. 2004) ("[I]ssue preclusion bars a party from relitigating an issue once it has suffered an adverse determination on the issue ....").

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2024 WL 2306248

District Court of Appeal of Florida, Third District.

AGENCY FOR HEALTH CARE ADMINISTRATION, Appellant,

v.

In re: Ryan Joseph SPENCE, Appellee.

No. 3D23-0552

|

Opinion Filed May 22, 2024

Synopsis

Background: Trustee of special needs trust petitioned to terminate trust and distribute all trust assets to sole beneficiary, and Agency for Health Care Administration (AHCA) objected, claiming, pursuant to trust's payback provision requiring distribution to AHCA for total medical assistance paid on behalf of beneficiary by Medicaid program upon trust termination, that it was owed for medical assistance payments made on behalf of beneficiary. The Circuit Court, Miami-Dade County, Jose L. Fernandez, J., granted trustee's petition, denied AHCA's objection and claim, and authorized distribution of all trust assets to beneficiary without reimbursing AHCA. AHCA appealed.

The District Court of Appeal, Scales, J., held that AHCA was entitled to reimbursement upon trust termination.

Reversed and remanded with instructions.

Procedural Posture(s): On Appeal; Judgment.

An Appeal from the Circuit Court for Miami-Dade County, Jose L. Fernandez, Judge. Lower Tribunal No. 15-580

Attorneys and Law Firms

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The Billbrough Firm, P.A., and G. Bart Billbrough, Coral Gables, for appellee Michael Morrison.

Before FERNANDEZ, SCALES and BOKOR, JJ.

Opinion

SCALES, J.

***1** The Florida Agency for Health Care Administration ("AHCA") appeals a February 22, 2023 probate court final order that authorizes the trustee to distribute the trust assets of the Ryan Joseph Spence Special Needs Trust Agreement ("Trust"), without enforcing the Trust's "payback" provision. The Trust's "payback" provision provides that, upon termination of the Trust, the trustee shall first distribute to AHCA "an amount equal to the total medical assistance paid on behalf of the Beneficiary by the Medicaid program." Because the Trust's "payback" provision is clear and unequivocal, we reverse the challenged order and remand with instructions for the probate court to enforce the Trust's "payback" provision in the event the trustee wishes to continue in his efforts to terminate the Trust.

I. RELEVANT FACTS AND PROCEDURAL BACKGROUND

A. Ryan's adoption by Kathleen and subsequent creation of the Trust

In September 2004, Kathleen Spence ("Kathleen") adopted Ryan Joseph Spence ("Ryan"), who was born in 2002. As part of Ryan's adoption, Kathleen and the Florida Department of Children and Families ("Department") entered into an Adoption Assistance Agreement ("Adoption Agreement"), relating to subsidy payments and services. The Adoption Agreement provided that the Department would provide a maintenance subsidy and a medical subsidy (Medicaid benefits as provided under Article XIX of the Social Security Act) for Ryan's benefit. Following Ryan's adoption, Medicaid payments were made on Ryan's behalf as contemplated by the Adoption Agreement.

After Kathleen's death in 2015, Kathleen's estate pursued a wrongful death action, which resulted in a settlement. Michael Morrison ("Morrison") and Ashley Nichole Spence ("Ashley") (together, Petitioners) were appointed as co-guardians of the person and property of Ryan and as co-trustees of Kathleen's estate. In November 2015, the probate court entered an order approving the wrongful death settlement and allocating the settlement proceeds

between Kathleen's two, minor children, including Ryan. Further, because Ryan was a Medicaid beneficiary suffering a disability, the probate court directed Morrison to establish a separate special needs trust for Ryan.

As directed, on November 10, 2015, Morrison established the Trust, which was funded with those proceeds from Kathleen's estate's settlement that were allocated to Ryan. The Trust was established in accordance with the Omnibus Budget Reconciliation Act of 1993, codified under 42 U.S.C. § 1396p(d)(4)(A) (§ 1917(d)(4)(A) of the Social Security Act); the Social Security Programs Operations Manual System (POM) SI 01120.203 ("POM"); and in accordance with Florida law. As is clear from the Trust document, the purpose of the Trust was to ensure that, notwithstanding Ryan's receipt of the settlement proceeds, Ryan would continue to be eligible for public subsidies.

Specifically, the Trust states that the intention of the Trust is "to satisfy Medicaid and Supplemental Security Income ... program requirements so that its establishment and funding do not prejudice the Beneficiary's eligibility for such public benefits." The Trust further provides that it is irrevocable and not subject to amendment, except on application of an interested party with court approval, and any amendment must be consistent with the intent of the Trust. As relevant to this appeal, Article Seven, Section 1 of the Trust provides:

> ***2 Section 1. Notice and Payback Provisions**
>
> It is the intent of this trust that the trust estate be exempt from being counted as an available resource to the Beneficiary under ... the Medicaid provisions of the Omnibus Budget Reconciliation Act of 1993, § 13611 (amending 42 United States Code § 1396p(d)(4)(A)), and implementing Medicaid regulations. The Trustee shall therefore comply with the following provisions.
>
> **A. Notices**
>
> On the death of the Beneficiary, or the earlier termination of this Trust, the Trustee shall give notice to the Third Party Liability (sic) of the Florida Agency for Health Care Administration ("AHCA")....
>
> **B. Distribution and payments**
>
> On the death of the Beneficiary or earlier termination of this trust, the Trustee shall first distribute to the Florida Agency for Health Care Administration (hereinafter "AHCA"), then to any other appropriate State agency entitled to Medicaid reimbursement from the remaining principal and income of this trust, up to the amount remaining in this trust, an amount equal to the total medical assistance paid on behalf of the Beneficiary by the Medicaid program. The Trustee shall instead contact AHCA to obtain the dollar amount of medical assistance provided and then submit that amount, or amount remaining in this trust, whichever is less, to AHCA.

B. Petitioners seek to terminate the Trust and distribute its assets to Ryan

In January 2023, after Ryan met the age of majority and no longer suffered from any disability, Morrison, as trustee and co-guardian, and Ashley, as co-guardian, filed a petition in the probate court to Relinquish Restrictions and Distribute the Assets of the Trust to the Ward (the "Petition"). The Petition sought the termination of the guardianship and the Trust, and the distribution of all Trust assets to Ryan.

C. AHCA's objection to the Petition and proceedings thereon

AHCA, which is the agency responsible for Florida's Medicaid Program, filed an objection to the Petition, claiming it is owed $50,281.73 for medical assistance payments made on behalf of Ryan. AHCA's objection asserted that, pursuant to the Trust's "payback" provision, the Trustee must pay AHCA's reimbursement claim before distributing any Trust assets to Ryan.

On February 21, 2023, the probate court conducted a hearing on the Petition and AHCA's objection. At the hearing, Petitioners argued that the Trust should not be held responsible for any payments made on behalf of Ryan because the Adoption Agreement – between Kathleen and the Department – contained no provision requiring repayment of benefits the Department agreed to pay for Ryan's disability. Petitioners further argued that, following Kathleen's death, Morrison took on the role of Ryan's adoptive parent, raising Ryan to the age of majority. Due to Morrison's parenting, Ryan is no longer receiving Medicaid and is no longer disabled; thus, the assets in the Trust should be distributed to Ryan free of any claim by AHCA. Petitioners requested that the trial court enter an order relinquishing restrictions on the Trust and order that the assets in the Trust be distributed to Ryan.

***3** AHCA argued below, as it does here, that it is owed $50,281.73 for amounts expended to provide medical assistance to Ryan. AHCA asserted that, because the Trust was established pursuant to applicable federal law to allow Ryan to maintain his eligibility for Medicaid, and because the Trust contained the "payback" provision that was required by federal law to maintain Ryan's eligibility, the trustee was required to comply with the Trust's "payback" provision. See 42 U.S.C. § 1396p(d)(4)(A).

Without elaborating at the hearing, and without elaborating in the resulting order on appeal, the probate court granted the Petition; denied AHCA's objection and its claim for $50,281.73; and authorized the Trustee to distribute the Trust assets to Ryan without reimbursing AHCA. AHCA's appeal timely followed. [1]

II. ANALYSIS

AHCA argues the trial court erred by authorizing the trustee to terminate the Trust without enforcing the Trust's clear and unequivocal "payback" provision, that required, upon termination of the Trust, the repayment of the medical assistance benefits paid on Ryan's behalf. Based on our *de novo* review, [2] we agree with AHCA. The terms and intent of Ryan's Trust are clear and unambiguous, and therefore, the language in the Trust controls. See Nelson v. Nelson, 206 So. 3d 818, 819 (Fla. 2d DCA 2016) (noting that the trial court properly construed the trust settlor's intent "from the plain and ordinary meaning of the terms set forth" in the trust instrument).

A. The Trust's purpose and its "payback" provision

The Trust, which was established pursuant to, and authorized under, 42 U.S.C. § 1396p(d)(4)(A), was funded with the settlement proceeds derived from Kathleen's wrongful death claim. The primary benefit of the Trust was to ensure that, notwithstanding Ryan's receipt of those settlement proceeds, Ryan remain eligible for government assistance, such as Medicaid.

There is, though, a *quid pro quo* for this benefit: the Trust's "payback" provision. Under 42 U.S.C. § 1396p(d)(4)(A), trust assets, held in a trust complying with federal law that is established for the benefit of a disabled person under the age of 65, will not be counted for determining Medicaid eligibility "**if** the State will receive all amounts remaining in the trust ... up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan ...." (emphasis added). In conformity with 42 U.S.C. § 1396p(d)(4)(A), the Trust included this mandatory "payback" provision. Per the "payback" provision, until AHCA is repaid for the total medical assistance paid on Ryan's behalf by Medicaid, the remaining assets in the Trust cannot be distributed to Ryan.

Further, the Trust was also established in accordance with POM. The exceptions addressed in POM are referred to as the "Medicaid trust exceptions," and, in relevant part, they provide that, to qualify for the special needs trust exception under 42 U.S.C. § 1396p, "[t]he trust must provide payback for any State(s) that may have provided medical assistance under the State Medicaid plan(s) and not be limited to any particular State(s)." POMS SI 01120.203. Importantly, POM also provides that "Medicaid payback also cannot be limited to any particular period of time; for example, payback cannot be limited to the period after establishment of the trust." Id.

***4** Ryan's Trust was intentionally drafted to comply with these federal requirements which allowed Ryan to continue his Medicaid eligibility. Had the Trust not contained the clear and unambiguous "payback" provision, Ryan's receipt of the wrongful death settlement proceeds may have precluded Ryan's continued eligibility for Medicaid benefits.

B. The Adoption Agreement

Petitioners argue that the Trust's "payback" provision should not be enforced because the Adoption Agreement – established years before the Trust's creation – contains no provision requiring the reimbursement to the Department of benefits paid on Ryan's behalf. Petitioners' argument, though, misses the point. While the Adoption Agreement no doubt incentivized Kathleen to adopt Ryan, it is of little, if any, relevance in determining distribution of Trust assets. The Trust was created over a decade *after* the Adoption Agreement and its purpose was to allow Ryan to receive settlement proceeds while continuing to qualify for Medicaid benefits. Moreover, paragraphs 18 and 19 of the Adoption Agreement undercut Petitioners' argument. These provisions expressly contemplate Ryan's subsidies ceasing if his needs change. [3] Again, if not for the Trust (including its "payback" provision) and its disposition of the settlement proceeds, then Ryan's continued benefits could have been in jeopardy.

III. **CONCLUSION**

Based on the above analysis, we reverse the order under review and, to the extent that Petitioners seek to terminate the Trust, remand with instructions for the trial court to conduct those proceedings it deems necessary to enforce the Trust's "payback" provision.

Reversed and remanded.

All Citations

--- So.3d ----, 2024 WL 2306248, 49 Fla. L. Weekly D1080

Footnotes

1 We have jurisdiction pursuant to Florida Rule of Appellate Procedure 9.170(b) as the order under review rendered in this guardianship case determines the right or obligation of an interested person.

2 See Giller v. Grossman, 327 So. 3d 391, 393 (Fla. 3d DCA 2021) ("We review de novo a trial court's construction of trust provisions, as well as its interpretation or application of controlling statutes, common law rules, or legal principles.").

3 Paragraphs 18 and 19 of the Adoption Agreement provide:

> 18. [Adoptive Parent] will notify the [D]epartment in the event that the child ceases to be dependent upon us, or if there is any significant change of circumstances which would relate to our child's continued need for subsidy.
>
> 19. Our child's continued need for subsidy will be re-evaluated annually and a new agreement will be presented to us at least 45 days prior to the expiration of the 12th month.

2024 WL 2197220
Only the Westlaw citation is currently available.

SEE TX R RAP RULE 47.2 FOR
DESIGNATION AND SIGNING OF OPINIONS.

Court of Appeals of Texas, Corpus Christi-Edinburg.

In the MATTER OF the GUARDIANSHIP OF
Robert Lewis HINDMAN, an Incapacitated Person

NUMBER 13-22-00592-CV
|
Delivered and filed May 16, 2024.

ON APPEAL FROM THE COUNTY COURT AT LAW NO. 2 OF VICTORIA COUNTY, TEXAS

Attorneys and Law Firms

Stephen Carl, Jeffrey A. Armstrong, for Appellant.

Robert E. McKnight Jr., Jonathan R. Riehs, for Appellee.

Before Justices Longoria, Silva, and Peña

MEMORANDUM OPINION

Memorandum Opinion by Justice Longoria

***1** Appellee Virginia Hindman was appointed by the trial court as guardian of the person and estate of Robert Lewis Hindman, her husband. Subsequent to Virginia's appointment, appellant Joel Barham filed an amended "Motion to Set Aside Void Provisions of Order, and in the Alternative[,] Original Petition for Bill of Review," which we construe as an amended bill of review. The trial court denied Barham's amended bill of review. In two issues, which we address as one, Barham argues that the trial court abused its discretion when it denied his amended bill of review. We reverse and remand.

I. BACKGROUND

On May 5, 2022, Virginia filed her original application for appointment of guardian of the person and the estate of Robert. On the same date, Virginia filed a motion for appointment of an attorney ad litem for Robert. The next day, May 6, 2022, the trial court signed its order appointing an attorney ad litem for Robert.

On May 10, 2022, Virginia filed an amended application for appointment of guardian of the person and the estate of Robert. In her amended application, among other things, Virginia sought to be appointed as the guardian of the estate of Robert, specifically requesting

> 9. The power to create or change rights of survivorship on any and all [of Robert's] accounts including, but not limited to, accounts at Frost Bank, Frost Bank Wealthscape[,] and Navy Federal Credit Union.
>
> 10. The power to create or change a beneficiary designation on any and all [of Robert's] accounts including, but not limited to, accounts at Frost Bank, Frost Bank Wealthscape, and Navy Federal Credit Union[.]

On May 19, 2022, a "Physician's Certificate of Medical Examination" was filed into the proceeding. In the certificate, J. Armando Diaz, M.D., a physician, indicated that he had examined Robert on March 9, 2022 and indicated that, among other things, Robert was totally without capacity to care for himself and to manage his property. On the same day, a report by clinical neuropsychologist Jennie Rexer, Ph.D., was also filed into the case. Dr. Rexer conducted a neuropsychological evaluation of Robert and indicated in her report that Robert had "the presence of severe memory impairment relative to other males [of]his age and education," "significant decline in intellectual functioning," "[s]ignificant executive dysfunction," "[e]xpressive language impairments," and that "[his ability to] learn[ ] was moderately impaired." Dr. Rexer stated in her report that "[t]he severity and pattern of severely impaired memory including severely impaired storage/consolidation processes, executive dysfunction, expressive language changes, and intellectual decline are most consistent with a mild to moderate dementia, likely Alzheimer's disease."

On May 25, 2022, Robert's attorney ad litem filed his "Report of Attorney Ad Litem in Guardianship Proceeding." He opined in his report that "[Robert] cannot manage his person or his affairs and is in need of a Permanent Guardianship of his Person and Estate." He also recommended that the trial court "appoint [Virginia] as Guardian of [Robert's] Person and Estate" "[a]s a result of [the attorney ad litem's] investigation, the needs of [Robert] and the evidence offered in this case[.]"

***2** On May 26, 2022, the trial court held a hearing on Virginia's amended application. At the hearing, Virginia testified that Robert was diagnosed with mild cognitive impairment and placed in hospice care on March 9, 2022. Virginia also testified regarding Dr. Diaz's and Dr. Rexer's findings, and stated that Robert's mental capacity had further declined since his examinations by Dr. Diaz and Dr. Rexer in March. The trial court took judicial notice of Dr. Diaz's certificate and Dr. Rexer's report. Virginia stated that Robert had difficulty managing his affairs for the past three to four years, and that he had overdrawn on some accounts and unintentionally closed a bank account. Virginia also stated that Robert had named a distant relative, a "grandnephew" he barely knew, as the beneficiary of his investment retirement account (IRA), which was the main asset of his estate. Virginia did not testify as to the "grandnephew's" name, but expressed concern that Robert had "whittl[ed]" down his IRA and was giving it away to people. According to Virginia, prior to his dementia, it was not Robert's character to give money or most of his estate to people, including family members, that he really did not know. Virginia stated that the gift to the "grandnephew," among other things, demonstrated his decreased capacity and that he was no longer functioning at the level he had previously.

Virginia requested the trial court to appoint her as guardian of Robert's person and estate. Virginia requested the trial court to provide her with, among other things, the authority to manage Robert's financial accounts, including the power to create and change rights of survivorship and beneficiary designations. Virginia also specifically requested the power to change the beneficiary designation of Robert's IRA and to move the IRA to a different financial institution in order to remove the "grandnephew's" access to that account.

The trial court granted Virginia's amended application for guardianship and appointed Virginia as guardian of Robert's person and estate. The trial court's order provided Virginia, among other things:

> 23[.] The power to create or change rights of survivorship on any and all [of Robert's] accounts including, but not limited to, accounts at Frost Bank, Frost Bank Wealthscape, and Navy Federal Credit Union[.]
>
> 24[.] The power to create or change a beneficiary designation on any and all [of Robert's] accounts including, but not limited to, accounts at Frost Bank, Frost Bank Wealthscape, and Navy Federal Credit Union[.]

On July 5, 2022, Virginia filed her "Inventory, Appraisement, and List of Claims" into the proceeding. The filing stated that "This [i]nventory is produced by the undersigned V[irginia] ... indicating the assets of R[obert's e]state and their valuation as of the Guardian's qualification on May 26, 2022." The inventory indicated that Robert's estate included one account from Navy Federal Credit Union and two accounts from Frost Wealthscape, which were categorized as "cash assets." No other information was provided regarding these accounts. The inventory also indicated that Robert's estate contained no annuities, IRAs, life insurance, nor stocks, bonds, or securities.

On August 24, 2022, Barham's counsel filed his "Notice of Appearance," indicating that counsel was appearing on behalf of Barham, "an [i]nterested [p]erson, as defined in [§] 1002.018 of the Texas Estates Code." On September 14, 2022, Barham filed his original "Motion to Set Aside Void Provisions of Order, and in the Alternative[,] Original Petition for Bill of Review," and an amended version on October 12, 2022. In his amended filing, Barham alleged he was the named beneficiary of "one or more of Robert['s] ... accounts" prior to May 2022 and that the trial court's May 26, 2022 order had granted Virginia, as Robert's guardian, powers "not authorized in the Texas Estates Code, namely 'the power to create or change rights of survivorship on any and all [of Robert's] accounts' and 'the power to create or change a beneficiary designation on any and all [of Robert's] accounts.' " According to Barham, the complained-of powers were "void," and the trial court "did[not] have [the] jurisdiction or the power to grant [such] provisions in the [o]rder." Barham also cited to § 1056.101 of the Texas Estates Code and argued that he was entitled to a bill of review. *See* TEX. EST. CODE ANN. § 1056.101.

***3** Virginia filed a general denial in response to Barham's amended filing on October 12, 2022. The trial court held a hearing on Barham's amended filing on October 13, 2022 and heard arguments from the parties. At the beginning of the hearing, Virginia informed the trial court that she had a motion in limine "speaking to the standing of Mr. Barham," that she had provided a copy to Barham, but indicated that the motion had not actually been filed. [1] The trial court allowed Barham to respond to the un-filed motion. Barham's counsel stated that Barham had a long-term relationship with Robert, that he was a beneficiary of Robert's non-probated estate, and that he was an "interested person under the [C]ode." Virginia argued that Robert was at high risk of being financially exploited, that

Robert had previously been financially exploited by Barham, that Barham was an adverse party in the proceeding, and concluded that Barham "d[id] not have standing to contest this proceeding." Barham replied that he was not contesting the guardianship, but was rather asking the trial court to "void certain provisions of the Court's order in granting the guardianship, not the granting of the guardianship but some of the powers that the Court granted the guardian, because the Court doesn't have power or jurisdiction under the code to do so." Barham further stated that he was "not adverse" to Robert, that he had not been mentioned by name at "the hearing," and that there was no evidence that he had "financially exploited" Robert, and that Virginia's "testimony was she had concerns." The following exchange occurred:

> The Court: Okay. Well, let me do this—well, did you want to respond one more time, [Counsel for Virginia]?
>
> [Counsel for Virginia]: If I might interject, [Counsel for Barham] said that [Barham] was not mentioned during the hearing, and that's not true. At the time, we thought he was a grandnephew, and it wasn't until the small estates affidavit that was done where I found out that he wasn't a grandnephew. He was like first cousin once removed or something to that effect. And so he was mentioned over and over again, the grandnephew. That was referring to Joel Barham.
>
> [Counsel for Barham]: I don't see [Barham's] name in the transcript. That's all I was mentioning.
>
> [Counsel for Virginia]: [Barham's] name wasn't mentioned but he was referred to in the transcript. And I do think it's important that [Counsel for Barham] is not certified. I thought his partner would be here because of the necessity of certification to be able to argue things in guardianship court. I know he said that [Counsel for Barham] doesn't need certification to argue a void judgment, but he's talking a lot like he's an attorney representing an interested person in a guardianship, is what he's referring to.
>
> [Counsel for Barham]: And, I'm sorry, Judge, I thought we were talking about the motion in limine.
>
> The Court: Let me do this.
>
> [Counsel for Barham]: That's not mentioned in the—
>
> The Court: Let me take the motion in limine under advisement and what I'm probably going to do is give y'all a chance to supplement anything, but let me take that under advisement and let me just consider the main motion at this time. Probably what I'm going to do here is just consider the motion, maybe give y'all a chance to supplement it, and then make a decision, is what I'm inclined to do. So let me hear you—since you have the motion to set aside these provisions, which you're indicating are void, tell me about that motion.
>
> [Counsel for Barham]: Thank you, Judge.

The trial court continued hearing arguments over Barham's amended filing. Barham argued as he did in his amended bill of review, that nothing in the estates code authorized the trial court to grant the complained-of powers to a guardian. Virginia argued that there were several different statutes within the estates code that permitted those powers. The trial court did not rule on Barham's amended filing but set a schedule for the parties to file additional responses. No evidence was admitted at the hearing. Virginia's counsel also informed the trial court that Robert had passed away on June 11, 2022.

After the hearing, the parties filed responses, briefs and reply briefs in support of their positions. On November 28, 2022, the trial court entered its order denying Barham's "Amended Motion to Set Aside Void Provisions of Order, and in the Alternative[,] Original Petition for Bill of Review." The order did not contain findings of fact or conclusions of law, nor were any requested by the parties. This appeal ensued.

II. BILL OF REVIEW

***4** Barham filed original and amended versions of his combined "Motion to Set Aside Void Provisions of Order, and in the Alternative[,] Original Petition for Bill of Review." Because Barham's original and amended filings occurred more than thirty days after the trial court issued its May 26, 2022 order appointing Virginia as guardian of Robert's person and estate, we construe those filings as an original and amended bill of review. *See* TEX. R. CIV. P. 329b(d) ("The trial court, regardless of whether an appeal has been perfected, has plenary power to grant a new trial or to vacate, modify, correct, or reform the judgment within thirty days after the judgment is signed."); *see also* TEX. R. CIV. P. 329b(f) ("On expiration of the time within which the trial court has plenary power, a judgment cannot be set aside by the trial court except by bill of review for sufficient cause, filed

within the time allowed by law"); TEX. EST. CODE ANN. § 1056.101 (providing that "[a]n interested person ... may, by a bill of review filed in the court in which the guardianship proceeding was held, have an order or judgment rendered by the court revised and corrected on a showing of error in the order or judgment"). Accordingly, we also construe the trial court's order at issue in this case as an order denying Barham's amended bill of review.

Barham lodges two issues on appeal. In his first issue, Barham argues the trial court abused its discretion "in denying the Motion to Void Provisions of Order." In his second issue, Barham argues that the trial court abused its discretion "in denying the Bill of Review." Because we construe Barham's combined filing as a bill of review, we address Barham's issues together.

A. Standard of Review and Applicable Law

A bill of review is a separate, independent suit, brought by a party to a former action, to set aside a final judgment that is no longer subject to a motion for new trial or appealable. *Frost Nat'l Bank v. Fernandez*, 315 S.W.3d 494, 504 (Tex. 2010); *Woods v. Kenner*, 501 S.W.3d 185, 190 (Tex. App.—Houston [1st Dist.] 2016, no pet.); *see also* TEX. R. CIV. P. 329b(f). We review a trial court's ruling on a bill of review for an abuse of discretion, indulging every presumption in favor of the court's ruling. *Woods*, 501 S.W.3d at 190; *Xiaodong Li v. DDX Grp. Inv., LLC*, 404 S.W.3d 58, 62 (Tex. App.—Houston [1st Dist.] 2013, no pet.). A trial court abuses its discretion if it acts in an unreasonable or arbitrary manner, or without reference to guiding rules and principles. *Woods*, 501 S.W.3d at 190; *Li*, 404 S.W.3d at 62.

A movant seeking an equitable bill of review must plead and prove (1) a meritorious defense to the underlying cause of action, (2) which the movant was prevented from making by the fraud, accident or wrongful act of the opposing party or official mistake, (3) unmixed with any fault or negligence on her own part. *Valdez v. Hollenbeck*, 465 S.W.3d 217, 226–27 (Tex. 2015) (elements of "equitable bill of review"). However, statutory bills of review, such as the one authorized by § 1056.101 of the Texas Estates Code, are not subject to the same limitations or requirements of an equitable bill of review. *Woods*, 501 S.W.3d at 191; *see also Valdez*, 465 S.W.3d at 226–27 ("Statutory bills of review are more scarce, existing predominately in the probate and guardianship contexts."); *McDonald v. Carroll*, 783 S.W.2d 286, 288 (Tex. App.—Dallas 1989, writ denied) (examining statutory bill of review found in the probate code). Section 1056.101 of the Texas Estates Code allows for a statutory bill of review in connection with guardianship proceedings, and provides that:

> (a) An interested person, including a ward, may, by a bill of review filed in the court in which the guardianship proceeding was held, have an order or judgment rendered by the court revised and corrected on a showing of error in the order or judgment.
>
> (b) Except as provided by [s]ubsection (c), a bill of review to revise and correct an order or judgment may not be filed more than two years after the date of the order or judgment.

TEX. EST. CODE ANN. § 1056.101(a), (b). The purpose of a statutory bill of review, such as that found in § 1056.101, is to "revise and correct errors, not merely to set aside decisions, orders, or judgments rendered by the probate court." *Nadolney v. Taub*, 116 S.W.3d 273, 278 (Tex. App.—Houston [14th Dist.] 2003, pet. denied). "[T]he interested party is required to allege and prove that the trial court committed substantial error." *Ablon v. Campbell*, 457 S.W.3d 604, 609 (Tex. App.—Dallas, 2015, pet. denied) (interpreting statutory bill of review found in former § 657 of the Texas Probate Code (now TEX. EST. CODE ANN. § 1056.101(a)) and citing *In re Guardianship of Winn*, 372 S.W.3d 291, 294–95 (Tex. App.—Dallas 2012, no pet.)). Section 1002.018 of the Texas Estates Code defines an "interested person" as:

> ***5** (1) an heir, devisee, spouse, creditor, or any other person having a property right in or claim against an estate being administered; or
>
> (2) a person interested in the welfare of an incapacitated person.

TEX. EST. CODE ANN § 1002.018. Thus, we must determine whether all the elements of the statutory bill of review were established, i.e.: whether (1) an interested person (2) filed a timely bill of review, and (3) showed substantial error in the order or judgment. *See id.* §§ 1002.18, 1056.101(a), (b); *see also Buck v. Estate of Buck*, 291 S.W.3d 46, 53 (Tex. App.—Corpus Christi–Edinburg, 2009 no pet.) (reviewing a bill of review filed under former § 657 of the Texas Probate Code and holding that "[i]n an appeal from the denial of a statutory bill of review, [an appellate court] determine[s] ... whether (1) an interested person (2) filed a timely bill of review, and (3) showed substantial error").

B. Discussion

In his brief, Barham argues that he established every element required for a statutory bill of review under the Texas Estates Code. In her brief, Virginia argues that Barham failed to establish that he qualified as an "interested person" or showed substantial error. [2]

1. Interested Person

We first address whether Barham established that he was an "interested person." Virginia argues, among other things, that Barham "has never stated any 'property right in or claim against' [Robert]'s estate while it is being administered." *See* TEX. EST. CODE ANN § 1002.018(1). We disagree. Barham's amended bill of review alleged that prior to May 2022—before Virginia was appointed as Robert's guardian—he was "named as the beneficiary of one or more of Robert['s] ... accounts." Barham further alleged that "Virginia ... was not happy about this fact and wanted to have the beneficiary designation changed," and that "[Virginia] sought to thwart [Robert's] wishes, defrauded th[e] [c]ourt by requesting powers that are not authorized by the Texas Estates Code, and changed the non-probate beneficiary designations of [Robert] to herself." In addition, Virginia testified at the hearing on her application for guardianship that Robert had named a distant relative, a "grandnephew," as the beneficiary of his IRA, which she stated was the main asset of his estate. Virginia also testified that Robert had "whittl[ed]" down his IRA and was giving it away to people, and that she wanted to be able to change the beneficiary designation on that IRA account. Though Virginia did not testify as to the "grandnephew's" name, Virginia's counsel argued at the hearing on Barham's amended bill of review that Virginia's testimony regarding the beneficiary referred to Barham.

Moreover, at the hearing on Barham's amended bill of review, the trial court was informed that Robert had died on June 11, 2022. Under the Texas Estates Code, a "ward" is "a person for whom a guardian has been appointed." *Id.* § 1002.030. An "estate" is "a ward's or *deceased ward's property.*" *Id.* § 1002.010 (emphasis added). A ward's estate does not cease to exist at the ward's death. *In re Guardianship of Bayne*, 171 S.W.3d 232, 236 (Tex. App.—Dallas 2005, pet. denied) (approving the payment of attorney's fees from the ward's estate after the ward's death). The Texas Estates Code requires the trial court to settle and close a guardianship proceeding upon the death of the ward. *See id.* §§ 1202.001(b)(1), 1204.001(a), (b)(1) (providing guardianship and guardianship of estate shall be settled and closed when ward dies). Here, it is undisputed that the trial court had not yet settled and closed the guardianship proceeding prior to the time Barham filed his amended bill of review. Thus, even after Robert's death, Robert's estate was being administered by Virginia as guardian of his estate at the time Barham filed his amended bill of review. Under these circumstances, we hold that Barham pleaded and proved that he was an "interested person" under the estates code. [3] *See id.* § 1002.018(1).

2. Substantial Error

***6** Barham argues, among other things, that "[']the power to create or change rights of survivorship on any and all [of Robert]'s accounts[']' and [']the power to create or change a beneficiary designation on any and all [of Robert]'s accounts[']" were not authorized by the Texas Estates Code.

Section 1151.101 provides that the guardian of the estate of a ward is entitled to:

> (1) possess and manage all property belonging to the ward;
>
> (2) collect all debts, rentals, or claims that are due to the ward;
>
> (3) enforce all obligations in favor of the ward;
>
> (4) bring and defend suits by or against the ward; and
>
> (5) access the ward's digital assets as provided by Chapter 2001.

TEX. EST. CODE ANN. § 1151.101. In the management of a ward's estate, the guardian of the estate is governed by the provisions of Title Three of the Texas Estates Code, named "Guardianship and Related Procedures." *Id.* § 1151.101(b).

Under § 1151.103, the guardian of an estate of a ward may, without application to or order of the court:

> (1) release a lien on payment at maturity of the debt secured by the lien;
>
> (2) vote stocks by limited or general proxy;
>
> (3) pay calls and assessments;
>
> (4) insure the estate against liability in appropriate cases;
>
> (5) insure estate property against fire, theft, and other hazards; and
>
> (6) pay taxes, court costs, and bond premiums.

Id. § 1151.103(a). None of the provisions of § 1151.103 provide Virginia, as guardian of Robert's estate, authority to exercise the complained-of powers.

On written application to the court, a guardian of the estate may take an action described by § 1151.102(c) if the guardian considers the action in the best interests of the estate and the action is authorized by court order. *Id.* § 1151.102(b). A guardian of the estate who complies with § 1151.102(b) may:

(1) purchase or exchange property;

(2) take a claim or property for the use and benefit of the estate in payment of a debt due or owing to the estate;

(3) compound a bad or doubtful debt due or owing to the estate;

(4) make a compromise or a settlement in relation to property or a claim in dispute or litigation;

(5) compromise or pay in full any secured claim that has been allowed and approved as required by law against the estate by conveying to the holder of the secured claim the real estate or personal property securing the claim:

(A) in full payment, liquidation, and satisfaction of the claim; and

(B) in consideration of cancellation of a note, deed of trust, mortgage, chattel mortgage, or other evidence of a lien that secures the payment of the claim;

(6) abandon worthless or burdensome property and the administration of that property;

(7) purchase a prepaid funeral benefits contract; and

(8) establish a trust in accordance with 42 U.S.C. § 1396p(d)(4)(B), and direct that the income of the ward as defined by that section be paid directly to the trust, solely for the purpose of the ward's eligibility for medical assistance under Chapter 32, Human Resources Code.

Id. § 1151.102(c). Virginia argues that the complained-of powers were authorized by § 1151.102(c)(3), which permits a guardian to "compound a bad or doubtful debt due or owing the estate." We disagree, as said provision, on its face, makes no mention of the power to create or change rights of survivorship and beneficiary designations as neither are "debts." *Id.* § 1151.102(c)(3). We further hold that none of the actions described by § 1151.102(c) provides Virginia, as guardian of Robert's estate, authority to exercise the complained-of powers.

***7** Virginia also argues that the list of actions that a guardian may do with court authorization under § 1151.102(c) is not exclusive, and "does not exhaust the full range of what a guardian may appropriately do in managing the ward's property." In support of this argument, Virginia cites to *Benavides v. Alexander*, which we find inapposite as that case involved a challenge to a trial court's order that a ward, acting through the guardian of his estate, was entitled to possession and control of funds belonging to the ward in a joint account with a right of survivorship designation. 646 S.W.3d 14 (Tex. App.—San Antonio 2021, pet. denied). *Benavides* did not involve the issue before us, namely, whether the Texas Estates Code authorizes a guardian the power to create or change rights of survivorship and beneficiary designations on a ward's accounts.

Moreover, the Texas Estates Code makes plain that in managing a ward's estate, the guardian of the estate is governed by the provisions of Title Three of the Texas Estates Code. *See* TEX. EST. CODE ANN. § 1151.101(b). Thus, if there is any authority supporting the complained-of powers at all, it must be found within Title Three of the Texas Estates Code. *See id.* Virginia has not illuminated what provisions within Title Three authorize the complained-of powers, and we have found none. Having found no provisions within Title Three of the Texas Estates Code that authorize the complained-of powers, we conclude that Barham has pleaded and proved that the trial court committed substantial error in permitting Virginia, as guardian of Robert's estate, the power to create or change rights of survivorship and beneficiary designations on "any and all" of Robert's accounts. *See Ablon*, 457 S.W.3d at 609; *Buck*, 291 S.W.3d at 53. Thus, the trial court abused its discretion in denying Barham's amended bill of review. *See Woods*, 501 S.W.3d at 190; *Li*, 404 S.W.3d at 62. We sustain Barham's issue. [4]

III. CONCLUSION

We reverse the trial court's order denying Barham's amended bill of review and remand the case for further proceedings consistent with this opinion.

All Citations

Not Reported in S.W. Rptr., 2024 WL 2197220

Footnotes

1 The Clerks' record does not contain a filed motion in limine.

2 It is undisputed that Barham filed a timely bill of review. *See* TEX. EST. CODE ANN. § 1056.101(b).

3 Because we have found Barham as a person "having a property right in or claim against an estate being administered," we decline to address Virginia's other arguments that Barham is not an "interested person" under Texas Estate Code § 1002.018. *See* TEX. EST. CODE ANN. § 1002.018.

4 Having sustained Barham's issue, we do not address Barham's remaining arguments. *See* TEX. R. APP. P. 47.1.

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Court of Appeal, Second District, Division 3, California.

Patty WIEDNER, Plaintiff and Respondent,
v.
Charlyne STEVENSON, as Trustee, Etc., Defendant and Appellant.

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|
Filed May 13, 2024

APPEAL from orders of the Superior Court of Los Angeles County, Ana Maria Luna, Judge. Affirmed in part, reversed in part, and remanded. Los Angeles County Super. Ct. No. 19STPB11853

Attorneys and Law Firms

John Alan Cohan for Plaintiff and Respondent.

John A. Bunnett for Defendant and Appellant.

Opinion

EGERTON, J.

***1** Before her death, Roberta Louise Davis established a special needs trust—within her own inter vivos trust—to benefit her gravely disabled adult son Daniel L. Black during his lifetime. Daniel was under a Lanterman-Petris-Short (LPS) conservatorship. One of Roberta's sisters, appellant Charlyne Stevenson, was the successor trustee of Roberta's trust, trustee of Daniel's special needs trust, and a contingent, remainder beneficiary of Roberta's trust upon Daniel's death. Another sister, respondent Patty Wiedner, was excluded from the trust. She became involved in Daniel's care after Roberta's death in June 2016 and, in April 2019, succeeded the public guardian as Daniel's conservator. [1] At the heart of this appeal is a dispute between these sisters over payments Patty asked Charlyne to make to her from the trust. In the end, the probate court ordered Charlyne pay Patty from the trust: her conservator fees, costs she had advanced and incurred for Daniel's benefit, and her court-appointed attorney's fees and costs.

Charlyne appeals from that order, and the court's order awarding $1,750 in sanctions against Charlyne and her counsel after it denied Charlyne's motions for new trial and to set aside the judgment. Charlyne asserts several errors. She contends Patty had no standing or legal basis to demand her conservator fees and attorney fees be paid from the trust; substantial evidence did not support the expenses, fees, and attorney fees the court ordered to be paid; the sanctions were not justified or authorized by law; and irregularity in the proceedings and the exclusion of relevant evidence resulted in a miscarriage of justice requiring a new trial.

We conclude Patty had standing. We also conclude the terms of the special needs trust allowed reimbursement for some, but not all, of the expenditures Patty claimed and for her conservator fees, and substantial evidence supported the court's findings as to those expenditures. We reverse the court's order in part, however, to the extent it orders Patty be reimbursed for certain expenditures she incurred before her conservator appointment and for her attorney fees. We also reverse the court's sanctions award. We find no miscarriage of justice occurred.

FACTS AND PROCEDURAL HISTORY

1. *The trust and conservatorship*

Roberta created her living trust in September 2002. She amended and restated it in March 2010, naming her sister Charlyne as the successor trustee. The main asset of the trust was a single-family residence. Roberta died on June 30, 2016. As successor trustee, Charlyne sold the property, which netted $335,847 to the trust on August 29, 2016.

Roberta's trust included—as a sub-trust—a "special needs trust" [2] for the benefit of her adult son Daniel, who had schizophrenia and developmental disabilities. The sub-trust was known as the "Daniel L. Black Special Needs Trust" (SNT). Charlyne is also the trustee for the SNT.

***2** Around April 2009, before Roberta died, Daniel was placed under an LPS conservatorship. [3] His schizophrenia "made him 'clinically unstable' such that he was in

and out of hospitals when he was not housed in a facility." He had behavioral problems, such as "hitting himself, punching walls, disrobing in public, impulsivity and outbursts." The public defender represented Daniel in the LPS conservatorship proceedings. The mental health court appointed the public guardian (Ernest Baiden) as the conservator of Daniel's person and estate. [4]

Daniel received monthly social security and SSI; this constituted his "estate." From these funds, the public guardian paid for Daniel's clothing, room and board, and extra spending money (known as PNI) for personal items, "like soda and other treats." The public guardian paid Daniel's board and care facility about $1,050 a month and deposited $130 a month in PNI to Daniel's account with the facility (or $35 a month if he were in a skilled nursing facility). The public guardian also was responsible for making payments for Daniel's medical and dental care.

Daniel's conservatorship was renewed each year until his death in 2020. (See Welf. & Inst. Code, § 5361, subds. (a) & (b) [an LPS conservatorship automatically terminates one year after the appointment of the conservator unless the conservator, after determining the conservatorship is still required, petitions for reappointment for a succeeding one-year period].) The public guardian served as Daniel's conservator until April 2019 when Patty succeeded Baiden.

According to Roberta's trust, on her death, the remaining trust property was to be held in the SNT "to provide a supplemental and emergency fund to supplement any public benefits available to [Daniel] during his lifetime." On Daniel's death, the trustee (Charlyne) was to distribute any remaining trust property "outright" to herself, her daughter (Roberta's niece), and Roberta's great nephew (presumably, the niece's son).

Under the terms of the SNT,

> "No part of the income or principal of the trust shall be used to replace or supplant public benefits of any county or any state, federal, or other governmental agency that has a legal responsibility to serve persons with disabilities or conditions that are the same as or similar to those of [Daniel]. For purposes of determining [Daniel's] eligibility for public benefits, no part of the principal or undistributed income of the trust estate shall be considered available to him, and he shall have no right to compel the trustee to release principal or income to him or for his benefit or otherwise have any access to any of the trust assets." [5]

The SNT also directs that, if the trustee were asked to release trust funds to or on behalf of Daniel to pay for needs that public benefits "would be authorized to provide" in the absence of the SNT,

> ***3** "the trustee shall deny the request and take whatever administrative or judicial steps may be necessary to continue the eligibility of [Daniel] for all available public benefits, including obtaining a determination or declaration from a court of competent jurisdiction that the trust principal is not available to [Daniel] for purposes of determining his eligibility for any public benefits. Any expenses of the trustee in this regard, including reasonable attorneys' fees, shall be a proper charge to the trust estate."

The SNT mandates that, during Daniel's lifetime, "the trustee shall pay to or apply for the benefit of [Daniel] as much of the net income and as much of the principal of the trust as the trustee, in the trustee's sole discretion, from time to time deems necessary or advisable for the satisfaction of his special needs," meaning, "the requisites for maintaining the good health, comfort, safety, and welfare of [Daniel] when, in the discretion of the trustee, those requisites are not being provided for" by any public benefit program or person legally obligated to support Daniel. The SNT requires the trustee to "consult with any guardian, conservator, custodian, or other person who cares for [Daniel] regarding his special needs."

2. *Patty's involvement and appointment as conservator*

Patty, also Daniel's aunt, was not a named beneficiary or successor trustee of Roberta's trust. Patty had not visited Daniel in the seven years before Roberta's death, except maybe once in 2012 or 2013. After Roberta's death in June 2016, Patty began to visit Daniel regularly. She made various expenditures on his behalf, including paying for haircuts, sundries, and clothes; taking him to lunch; and depositing cash in his "account" with the facility where he lived to pay for extra treats. In January 2017, Patty asked John Bunnett, as the trustee's counsel, to reimburse her from the SNT for the money she had spent from July to December 2016. Bunnett refused. He told Patty's then-counsel that Patty was not authorized to make expenditures, or perform duties, on behalf of the SNT, and the listed expenses "were never communicated to or authorized by" Charlyne, as trustee.

At some point, Daniel developed extensive problems with his teeth. He had difficulty eating and pain, which he complained about to Patty. She began taking him to dental providers in December 2016. She obtained estimates for different treatment plans from various providers. In January 2017, a specialist at UCLA provided a $25,925 estimate for extractions, bone grafts, and dental implants. Patty apparently appeared before the mental health court in January 2017 to ask about getting Daniel's teeth fixed. In July, she wrote the judge in the LPS conservatorship proceeding to ask about having Daniel's teeth fixed, and included the estimate. [6]

There was a difference of opinion as to the best course of treatment for Daniel. In her July 2017 letter, Patty wrote she did not believe Daniel was a "good candidate" for partial dentures, as he likely would lose or break them. Baiden, on the other hand, wrote in a January 2018 memorandum, "Any attempt to have all of Mr. Black's teeth extracted for dental implants will be too invasive and not serve Conservatee's best interest."

***4** In August 2017, Baiden responded to the mental health court's inquiry as to whether a family member could be appointed as successor conservator for Daniel. He did not recommend Patty. Baiden described Charlyne and Patty as having an "intense sibling-rivalry." He was concerned Daniel "could possibly become a 'pawn' between his two Aunts." He noted Charlyne's appointment as Roberta's successor trustee "ha[d] bothered" Patty "a lot," and stated Patty was "doing everything possible to even have [*sic*] an invasive procedure to have [Daniel] go through an unnecessary and invasive dental procedure so the Trust will be drained." He believed Daniel's interests would best be served by the public guardian continuing as his conservator.

In January 2018, Baiden provided an update on recommendations he had received about Daniel's dental needs. Lumina Dental had identified 14 of Daniel's teeth that should be extracted and recommended upper and lower partial dentures. [7] Baiden also noted Daniel was "clinically unstable, going in and out of hospitals" due to behavioral problems. He "need[ed] to remain in a locked setting at th[at] time due to his ongoing behavioral problems."

In November 2018, Patty asked the public guardian to reimburse her for clothing and other items she had bought for Daniel. Baiden made clear, as he had told her previously, that "[a]ny purchases made for Danny by anyone, without prior authorization from [the] [p]ublic [g]uardian cannot be reimbursed," as the public guardian had to make those purchases directly. Baiden asked Patty to let him know if Daniel told her about specific items he needed.

On April 10, 2019—on Daniel's motion—the mental health court relieved the public guardian as conservator and appointed Patty as Daniel's LPS conservator of the person. Because Patty did not have an attorney, the court appointed one for her (Kelli Stanford). The court noted, "If there are needs that Mr. Black has—that need to be paid out of the special need[s] trust, I would expect that you would make a request for that. But if you're making extravagant request[s], then I'm going to be looking at the conservatorship."

On December 6, 2019, the mental health court relieved Stanford as Patty's counsel. The court appointed John Cohan to represent Patty, as Daniel's conservator, "for all purposes" under section 5370.1 of the Welfare and Institutions Code and ordered "[a]ttorney fees to be paid by Los Angeles County."

3. *Dispute over dental treatment leading to petitions*

In November 2019, Patty obtained estimates from Western Dental, but they did not involve implants. Patty wanted Daniel to have implants. Charlyne and attorney Bunnett did not believe Daniel would handle the procedure well, partly because it required anesthesia and he had apnea. In December 2019, Patty, through attorney Cohan, sent a demand that the SNT pay for proposed dental implant treatment, at first estimated to cost $21,850 and then increased to $50,465. Patty sought an order in the LPS conservatorship case authorizing her, as Daniel's conservator, to consent to dental treatment on his behalf. The court entered an order on January 8, 2020, authorizing Patty to consent on Daniel's behalf to dental implants or dentures, tooth extractions, bone grafts, other procedures, and anesthesia "as needed for the procedures."

Meanwhile, on December 20, 2019, Charlyne, as trustee, filed a petition under Probate Code [8] section 17200 et seq., amended on February 25, 2020, to bring the internal affairs of Roberta's trust and the SNT under the probate court's jurisdiction. [9] The petition sought, among other things, an order that she had "sole discretion to determine what expenditures" to make from the SNT and to deny expenditures she deemed inappropriate; a determination of the dental treatment Daniel required; instructions as to whether she had discretion to deny spending the requested funds on the dental treatment if she determined it was not in Daniel's best interest; and an order that she was not required

to reimburse Patty for any expenses she "purportedly made on behalf of Daniel" that Charlyne did not authorize in advance. The petition made various factual allegations, including that Patty was trying to drain the trust because she felt "spurned that she had been cut out of" the trust, and essentially had prevented Charlyne from seeing Daniel.

***5** Patty filed a response with objections to Charlyne's amended petition, raising issues of Charlyne's breach of her trustee and fiduciary duties, alleging ethical violations by her counsel, and asking for sanctions and damages. Patty alleged Daniel was in poor health, "exacerbated by long-standing and serious dental problems" that Charlyne had failed to pay for from the SNT. Patty alleged Charlyne had refused to pay for anything Daniel "need[ed] or ... requested" and had "abrogated her duties by delegating day-to-day trust[ ] administration and decision-making" to Bunnett. Patty asked the court to order Charlyne to pay for Daniel's dental procedures out of the SNT. The response also included a letter from prosthodontist Dr. Alfredo Paredes, who saw Daniel in May 2020. He recommended a full mouth reconstruction with dental implants under general anesthesia. The estimated cost was $65,000.

At a hearing on Charlyne's petition on July 31, 2020, after Dr. Paredes testified about Daniel's teeth and that he was suffering from infection that could not be managed long-term with antibiotics, the court ordered Charlyne to release $30,000 from the SNT to Patty by August 10, 2020, to begin Daniel's dental work. The court understood Daniel's treatment "would have to proceed in phases, including multiple stages to extract teeth and then place [the] implants, and that Daniel would have to be sedated with anesthesia." The court directed Patty to submit receipts for the use of the $30,000 to Bunnett, and appointed a guardian ad litem (GAL) for Daniel.

Bunnett filed an ex parte application asking the court to reconsider and/or stay its order directing Charlyne to release the funds to Patty. He argued the health department recently had expanded Medi-Cal dental benefits to include most of the treatment outlined by Paredes. [10] He contended the terms of the trust thus prevented Charlyne from releasing the funds to pay for the covered treatment. Patty opposed the application. Cohan declared he had contacted several Medi-Cal dental offices: they either did not provide the treatment Daniel needed or said they never had been able to get Medi-Cal to pay for dental implants. The court denied the application.

Sadly, on August 27, 2020, Daniel had his first dental procedure with Dr. Paredes and died.

On September 30, 2020, Charlyne filed her first and final account and report of trustee seeking reimbursement of costs, for her trustee's and her attorney's compensation, and for distribution of the trust estate. Ultimately, Charlyne sought $15,345.41 in trustee fees at $40 per hour; reimbursement of $1,284.47 in out-of-pocket expenditures for Daniel; and attorney fees for Bunnett totaling $47,318.15. Charlyne does not challenge the court's final order concerning these fees and costs.

On October 8, 2020, the court convened a hearing on Charlyne's first amended petition. The court assumed jurisdiction over Roberta's trust and the SNT and confirmed Charlyne as acting trustee of the trusts. The court ordered "that all proceedings involving the Trust and all proceedings arising under ... § 17200, et seq. be commenced in the Los Angeles Superior Court, Central District." The court denied Charlyne's other requests or found them moot. The court also gave "an OK to set any petition that should be considered in conjunction with the [trustee's] accounting for 2/18/2021." [11] The petition was to be filed and served by December 15, 2020.

In accordance with the court's order, on December 10, 2020, Patty filed a petition for the allowance of conservator's fees, reimbursement of costs advanced, and payment of costs incurred, and allowance of conservator's attorney's fees and costs, all to be paid from the SNT. Patty and Cohan asserted standing to bring the petition under sections 2640, 2641, and 2642. The petition alleged there was no conservatorship estate.

***6** Patty asked for reimbursement of out-of-pocket costs totaling $33,228.36 that she made for Daniel's benefit from July 2016 through July 25, 2020; $56,500 for transportation costs from July 2016 to July 15, 2020; and $8,000 in conservator fees as compensation for performing her duties as conservator under section 2641. Cohan asked for attorney fees from August 5, 2020 to the present. At $250 per hour they totaled $20,350, but had increased to $38,007.26 by the end of trial. He also asked for $1,082.26 in costs.

On May 3, 2021, the court set an evidentiary hearing for October 20, 2021, on the petition for conservator's fees and on the trustee's accounting. The minute order notes that all counsel/parties appeared by LACourtConnect.

The court heard testimony over three days on October 20, 2021, November 3, 2021, and January 31, 2022. Patty, her husband, Charlyne, Baiden, and Cohan testified. Bunnett requested a statement of decision. The court filed its proposed statement of decision on April 25, 2022. The court established equitable liens against the trust assets for reimbursement of monies to Patty and her conservatorship fees, and as to attorney fees payable to Cohan (and to Daniel's GAL). The court ordered Patty be reimbursed from the trust $32,198.36 in out-of-pocket expenses, $56,500 in transportation costs, and $8,000 in conservatorship fees; and Cohan be reimbursed $28,947.26 in attorney fees and costs. As to Charlyne's accounting, the court ordered her to pay from the trust $30,155.65 in attorney fees and $1,231.32 in costs to Bunnett, pay herself $5,760 in trustee fees, reimburse herself $1,284.47 in out-of-pocket costs, and pay the GAL $11,141.88.

Charlyne objected to the proposed statement of decision. The court overruled the objections on May 25, 2022, declared its statement of decision final, and entered its order on Patty's petition on June 24, 2022 and on Charlyne's accounting on July 1, 2022.

On July 15, 2022, Charlyne filed notices of intention to move for a new trial and to set aside the judgment and enter a different judgment under section 663 of the Code of Civil Procedure. She argued the court abused its discretion in not conducting the trial in open court and excluding evidence relevant to her case, and awarded excessive "damages." Charlyne argued the judgment should be set aside because it was based on an error of law, namely, that no legal basis existed to compel the SNT to reimburse Patty for the expenses she claimed or to pay her conservator or attorney fees. She also argued the trial evidence was insufficient to support the court's order.

The court denied the motions on September 2, 2022. On Cohan's request for sanctions in his joint opposition to the motions, the court also ordered Charlyne and Bunnett to pay, jointly and severally, sanctions of $1,750.

Charlyne appealed from the "judgment" on Patty's petition for conservator fees, reimbursement of costs, and attorney fees; from the "judgment" on trustee's first and final account —but only to the extent it ordered Charlyne, as trustee, to pay the amounts granted in Patty's petition; from the court's orders denying Charlyne's motions for new trial and to vacate the judgment and enter a new judgment; and from the court's order imposing sanctions.

DISCUSSION

Charlyne contends: (1) the probate court abused its discretion in directing Charlyne, as trustee, to pay from the trust Patty's conservator fees and costs allegedly expended for Daniel's benefit and her attorney fees allegedly incurred for Daniel's or the trust's benefit; [12] (2) irregularity in the proceedings and the court's exclusion of evidence resulted in a miscarriage of justice requiring a new trial; (3) substantial evidence does not support the court's awards on Patty's petition, in any event; and (4) the court abused its discretion in imposing $1,750 in sanctions against Charlyne and Bunnett.

1. *Standards of review*

***7** As this appeal primarily is from a judgment based on a statement of decision after a bench trial, "we review the trial court's conclusions of law de novo and its findings of fact for substantial evidence." (*McPherson v. EF Intercultural Foundation, Inc.* (2020) 47 Cal.App.5th 243, 257.) We resolve " 'any conflict in the evidence or reasonable inferences to be drawn from the facts ... in support of the determination of the trial court['s] decision.' " (*Estate of Young* (2008) 160 Cal.App.4th 62, 75–76.) "We may not reweigh the evidence and are bound by the trial court's credibility determinations." (*Id.* at p. 76.)

Where the trial court's orders are based on the exercise of its discretion—such as the award of conservator fees, expenses, and attorney fees here—we apply the abuse of discretion standard of review. (See, e.g., *Conservatorship of Levitt* (2001) 93 Cal.App.4th 544, 549 [determination of what constitutes reasonable attorney fees is committed to the discretion of the trial court]; § 2640, subd. (c) [court determines if compensation requested by conservator is "just and reasonable"]; cf. *In re Fraysher's Estate* (1956) 47 Cal.2d 131, 136 ["In passing upon the reasonableness and necessity of expenditures during [estate] administration, the court below is vested 'with a broad discretion,' which will not be disturbed on appeal except when abused."].) A court abuses its discretion if it exceeded the bounds of reason or contravened the uncontradicted evidence, failed to follow proper procedure in reaching its decision, or applied the wrong legal standard to the determination. (*Dunlap v. Mayer* (2021) 63 Cal.App.5th 419, 424.)

To the extent the court's orders depend on its interpretation of statutes or of the trust instruments at issue, however, our review is de novo. (*Pena v. Dey* (2019) 39 Cal.App.5th 546, 551, disapproved on other grounds by *Haggerty v. Thornton* (2024) 15 Cal.5th 729 [de novo standard of review applies to questions of statutory interpretation and to interpretation of trust instrument where interpretation does not depend on extrinsic evidence]; see also *Conservatorship of Whitley* (2010) 50 Cal.4th 1206, 1213 [on review of an award of attorney fees after trial, normal standard of review is abuse of discretion; however, de novo review of such a trial court order is warranted where the determination of whether the criteria for an award of attorney fees and costs have been satisfied amounts to statutory construction and a question of law].)

We review the propriety of the trial court's ruling, not its reasoning, and "may uphold the ruling 'on any basis presented by the record whether or not relied upon by the trial court.' " (*Alamo v. Practice Management Information Corp.* (2013) 219 Cal.App.4th 466, 481, fn. 5.)

2. *Standing*

Charlyne, as she did below, first contends Patty lacked standing to bring her petition because Patty was neither a trustee nor a beneficiary of the trust. "The probate court has general power and duty to supervise the administration of trusts." (*Schwartz v. Labow* (2008) 164 Cal.App.4th 417, 427 (*Schwartz*).) Section 17200 authorizes a trustee or beneficiary to petition the probate court "concerning the internal affairs of the trust," including to "[s]ettle the accounts and pass[ ] upon the acts of the trustee, including the exercise of discretionary powers." (§ 17200, subds. (a), (b)(5); *Schwartz,* at p. 427 ["[p]roceedings in the probate court 'concerning the internal affairs of the trust' are commenced with the filing of a petition"].) Under section 17206, the probate court "in its discretion may make any orders and take any other action necessary or proper to dispose of the matters presented by the petition."

***8** Here, Charlyne's section 17200 petition raised the issue of her discretionary powers under the trust to decide when to expend SNT funds for Daniel's needs. She specifically asked the court for an order that she was "not required to reimburse Patty ... for any of the expenses purportedly made on behalf of Daniel ... not authorized by the Trustee beforehand, and if Patty ... wishes to duplicate or supplement efforts of the Trustee in providing for the needs of Daniel ..., such expenses are of her own choosing and not reimbursable by the [SNT]." She also asked the court to order "any and all matters concerning the internal affairs of the trust be brought in the Probate Department of the Los Angeles Superior Court." The court so ordered after assuming jurisdiction over the trusts.

Whether Charlyne abused her discretion as trustee of the SNT in denying reimbursement of expenditures made on Daniel's behalf concerned the propriety of "the acts of the trustee" and was "a matter presented by the petition." Having raised the issue in her own petition, Charlyne cannot now claim Patty had no standing to ask the court—as part of the action Charlyne commenced—for reimbursement from the SNT of her expenses incurred for Daniel's benefit.

Relatedly, Charlyne contends the court had no authority to issue an equitable lien against the trust because the trust assets vested in the remainder beneficiaries on Daniel's death. The court's broad powers under section 17200 enabled the court to consider the acts of the trustee, including the propriety of the trustee having withheld her discretion to release trust funds for Daniel's benefit—despite his untimely death. Having found the trustee was in breach of trust, we conclude the court could impose an equitable lien to remedy that breach in light of the unique circumstances before it. (See *Farmers Ins. Exchange v. Zerin* (1997) 53 Cal.App.4th 445, 453 [equitable liens may arise out of general considerations of right and justice as applied to the relations of the parties and the circumstances of their dealings; they frequently are based on the equitable maxim that "equity will deem as done that which ought to be done"].) "To preserve [a] trust and to respond to perceived breaches of trust, the probate court has wide, express powers to 'make any orders and take any other action necessary or proper to dispose of the matters presented' by [a] section 17200 petition." (*Schwartz, supra*, 164 Cal.App.4th at p. 427.)

Moreover, Charlyne also filed a first and final account and report of trustee, asking the court to disburse trust funds to Charlyne and her attorney, and distribute the balance of the trust estate to the three remaining beneficiaries. Charlyne's request to settle her account—which arose from the filing of her section 17200 petition—"activated the probate court's duty and authority to scrutinize the appellant's account." (*Schwartz, supra*, 164 Cal.App.4th at p. 427 ["Presented with a section 17200 petition to settle an account, 'the probate court has a duty *imposed by law* to inquire into the prudence of the trustee's administration.' "].) The court could not do so without also considering any claims for reimbursement raised by Patty. The court had the " '*inherent power* to decide all incidental issues necessary to carry out its

express powers to supervise the administration of the trust.' " (*Ibid.*) In any event, the court specifically told Patty—if she planned to seek reimbursement for any expenses—"that should be something that is brought before the court." The court's minute order indicated it had given "an OK to set any petition that should be considered in conjunction with the [trustee's] accounting for 2/18/2021."

Finally, we agree with Patty that, as Daniel's conservator, [13] she had standing to bring her petition under sections 2641 and 2642. As we discuss in detail below, those sections expressly authorize a conservator and her attorney to petition the court for conservator and attorney fees. (Whether those sections authorized the court to direct the trust to pay conservator fees and appointed counsel's fees versus whether the court could hear Patty's petition at all is a different question that we address below.) And, as the court noted in denying Charlyne's motion to set aside the judgment, section 2623 authorizes a conservator to seek "[t]he amount of the reasonable expenses incurred in the exercise of the powers and the performance of the duties of the ... conservator." (§ 2623, subd. (a)(1).) Accordingly, we conclude Patty had standing to file her petition.

3. *The SNT was not part of Daniel's "estate"*

***9** Patty brought her petition for conservator fees, reimbursement of expenses, and attorney fees under sections 2640, [14] 2641, and 2642. Section 2641 allows a conservator of the person to petition the court (in a conservatorship proceeding) for "an order fixing and allowing compensation for services in the best interest of the ... conservatee rendered to that time." (§ 2641, subd. (a).) "The compensation allowed shall thereupon be charged against the estate." (*Id.*, subd. (b).) Section 2642, in turn, permits an attorney who has rendered legal services to a conservator to petition the court for "an order fixing and allowing compensation" for those legal services. (§ 2642, subd. (a).) Again, any compensation allowed "shall ... be charged against the estate." (*Id.*, subd. (b).) Finally, section 2646 provides: "In proceedings under this chapter [governing compensation of guardian, conservator, and attorney], the court shall only determine fees that are payable from the estate of the ... conservatee and not limit fees payable from other sources."

Patty had argued—as she does on appeal—that the SNT was part of the conservatee's (Daniel's) estate and thus reachable to pay her conservator and attorney fees under these statutes. Charlyne contended—as she does on appeal—the SNT was not part of the conservatee's estate and thus there was no authority to direct the trust to pay Patty's conservator and attorney fees. We agree with Charlyne that the SNT is not part of Daniel's "estate."

Patty relies on both section 2586 and 2400. Section 2586 states, the " 'estate plan of the conservatee' includes, but is not limited to, ... any trust of which the conservatee is the settlor or beneficiary." (§ 2586, subd. (a).) But sections 2641, 2642, and 2646 refer to the conservatee's "estate," not "estate plan." Thus, section 2586 is not relevant to our analysis. Section 2400 defines " '[e]state' " as "all of the conservatee's personal property, wherever located, and real property located in this state." (§ 2400, subd. (b).) Section 2640.1, which also is inapplicable to the situation before us, provides, "[i]f a conservator of the estate is not appointed, but a conservator of the person is appointed, the compensation and costs allowed [to the individual who was not appointed conservator] shall be ordered by the court to be paid from property belonging to the conservatee, whether held outright, in trust, or otherwise." (§ 2640.1, subd.(c).)

Patty argues the SNT was part of Daniel's estate because, "[a]t the time [it] was established, Daniel acquired a *vested* property interest in the trust, to be disbursed according to criteria set forth in the instrument." She cites *Anderson v. Superior Court* (1983) 142 Cal.App.3d 112 (*Anderson*) for the proposition that, " 'the beneficiaries [of a trust] are the real owners of the property.' " (Quoting, *id.* at p. 117, alteration in respondent's brief.)

The trust in *Anderson* was nothing like the trust here. The trust there was created to sell real property and distribute the proceeds of the sale to the beneficiaries. The trustee had no other power over the property. (*Anderson*, *supra*, 142 Cal.App.3d at p. 116.) The quotation that Patty altered from the case stated: "Thus, the trust is a naked, dry trust, and the beneficiaries are the real owners of the property." (*Id.* at p. 117.) Although that may have been the case in *Anderson,* that is not the case with respect to a third-party special needs trust like the one at issue here.

Daniel was not the owner of any of the assets in the SNT. He was the beneficiary of what is known as a "third-party" special needs trust. A third-party special needs trust—in contrast to a "first-party" special needs trust—"is established by one person (usually a parent) using his or her own funds for the benefit of another, the person with a disability. It does not involve any assets of the person with a disability." (See

Fay Blix, *The World of Special Needs Trusts* (Nov. 2008) 50 Orange County Lawyer 10, *11 (Blix); see also Hook & Kefalas Dudek, Special Needs Trust Handbook (Dec. 2023) § 5.01[B] (Hook) [a third-party special needs trust preserves "public benefits for the trust beneficiary while supplementing the beneficiary's lifestyle with private funds" and "protect[s] the private third-party funds from the state"].)

***10** "The purpose of a special needs trust is 'to enhance the beneficiary's quality of life through the purchase of additional goods and services that are not covered or adequately provided by SSI ... and Medicaid.' " (*Gonzalez v. City National Bank* (2019) 36 Cal.App.5th 734, 743–744 (*Gonzalez*).)

On Daniel's death, any funds remaining in the SNT would go to the named remainder beneficiaries. More importantly, although the purpose of the SNT was "to supplement any public benefits available to [Daniel] during his lifetime," he had "no right to compel the trustee to release principal or income to him or for his benefit or otherwise to have any access to any of the trust assets." Accordingly, the trust funds were not available to him and thus not part of his estate.

A first-party or self-settled special needs trust, on the other hand, is funded by the disabled person's *own* assets. (Blix, *supra*, at *11.) Those assets are not considered in determining the beneficiary's eligibility for needs-based benefits like SSI and Medi-Cal. (*Ibid*.) After the beneficiary dies, however, the government provider of the benefits, such as Medi-Cal, is entitled to reimbursement from any funds left in the first-party special needs trust. (See *Gonzalez, supra*, 36 Cal.App.5th at p. 744 ["so long as the state will recover for the Medicaid services provided to the special needs trust beneficiary during her lifetime, the beneficiary remains eligible for such services, even if the amount in the trust otherwise would disqualify the beneficiary from receiving such benefits"]; *id.* at p. 745 ["California regulations also provide that for a qualifying special needs trust to be considered 'not available' when determining Medi-Cal eligibility, the trust must be set up so that '[t]he State receives all remaining funds in the trust, or respective portion of the trust, upon the death of the individual ... up to an amount equal to the total medical assistance paid on behalf of that individual by the Medi-Cal program' "]; 42 U.S.C. § 1396p(d)(4)(A) [trust containing assets of a disabled individual under age 65 established for the individual's benefit is not considered in determining individual's eligibility for state Medicaid benefits if the state "will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total" benefits paid].)

A third-party special needs trust, however—because it is not funded by the *beneficiary's* assets—need not include such a "payback provision." (Loring & Rounds, A Trustee's Handbook—Rounds and Rounds (2024) § 9.3, p. 1482 & fn. 25; Special Needs Alliance, Administering a Special Needs Trust: A Handbook for Trustees (2024) p. 5 <https://www.specialneedsalliance.org/wp-content/uploads/2024/01/SNA-2024-Handbook.pdf> [as of May 10, 2024], archived at <https://perma.cc/3GVZ-EWUL> (Handbook) [self-settled special needs trusts, unlike third-party trusts, "must include a provision directing the trustee, if the trust contains any funds upon the death of the beneficiary, to pay back anything the state Medicaid program has paid for the beneficiary"]; *id*. at p. 6 [third-party special needs trust is established by someone other than the person with disabilities "with assets that never belonged to the beneficiary" and are not required to include a " 'payback' provision for Medicaid benefits upon the beneficiary's death"].)

***11** The California cases on which Patty relies to argue the SNT was part of Daniel's estate do not involve third-party special needs trusts. Rather, in all of them, the trusts were funded with assets belonging to the settlor.

In *Riverside County Public Guardian v. Snukst* (2022) 73 Cal.App.5th 753, the reviewing court found assets of the revocable inter vivos trust of a deceased settlor, who also was a conservatee and Medi-Cal recipient, constituted his estate for purpose of Medi-Cal reimbursement. (*Id.* at pp. 756–757.) Thus, the trial court should have reimbursed the state from the trust for the Medi-Cal benefits it had provided to the conservatee/settlor during his lifetime before distributing the assets to the trust's beneficiary. (*Ibid.*) Similarly, in *Belshé v. Hope* (1995) 33 Cal.App.4th 161, 163–165, 175, the court held real property a Medi-Cal recipient had passed to beneficiaries to her inter vivos trust on her death was part of the benefit recipient's estate—despite its transfer—from which the state could seek reimbursement of Medi-Cal benefits it had provided her. Under this reasoning, perhaps if Patty had been Roberta's conservator, Roberta's estate would have included the assets in the trust that were to be distributed to the remainder beneficiaries. *Belshé* thus reinforces Charlyne's point that the assets in the SNT were part of Roberta's—not Daniel's—estate.

Finally, Patty cites *Gonzalez, supra*, 36 Cal.App.5th 734, for its statement, " '[u]pon the death of the beneficiary of a special needs trust, any remaining assets in the trust are treated as part of the beneficiary's estate.' " (*Id.* at p. 751, quoting *Shewry v. Arnold* (2004) 125 Cal.App.4th 186, 197.) Patty, however, omits the important qualifier: " '*for purposes* of Medi-Cal reimbursement.' " (*Gonzalez*, at p. 751, italics added, quoting *Shewry*, at p. 197.) Moreover, the court in *Gonzalez* was describing *Shewry's* discussion of section 3605, which "applies only to a special needs trust established under Section 3604." (§ 3605, subd. (a).) Section 3604 governs the establishment of a special needs trust when the court has ordered that "money of a minor or person with a disability be paid to a special needs trust"—in other words, a first-party trust. (§ 3604, subd. (a)(1).)

In *Gonzalez*, the plaintiffs' daughter was severely disabled due to complications during her birth. After the daughter received a multi-million-dollar settlement in a medical malpractice lawsuit, a court placed the settlement proceeds in a special needs trust with the daughter as the beneficiary. (*Gonzalez, supra*, 36 Cal.App.5th at pp. 739–740.) On the daughter's death, her parents argued the remainder of the trust should be distributed to them. The court, however, found the state was entitled to reimbursement for the Medi-Cal benefits it had provided the daughter from the funds remaining in the trust after her death. (*Id.* at pp. 739, 741–742.) The trust included the required " 'payback' provision" that—under the applicable federal statute—on termination of the trust, the residual shall be payable to any state or state agency that has provided state medical benefits to the beneficiary. (*Id.* at p. 763.)

Again, unlike the assets used to fund the SNT here, assets placed in a special needs trust established under section 3604 *belong* to the beneficiary. Those assets—e.g., funds from an injury settlement—otherwise would have been paid directly to the beneficiary. Thus, absent the creation of the special needs trust in *Gonzalez*, the assets would have been considered in determining the daughter's eligibility for public benefits and she likely would have lost those benefits. Roberta, however, placed her *own* assets—not Daniel's assets—in the SNT created for him. Nor is there any similar "payback" provision in the SNT, nor was one required.

***12** As Charlyne notes, the Law Revision Commission Comments to section 3605 state, "On the death of the special needs trust beneficiary or on termination of the trust, trust property may become subject to reimbursement claims under federal or state law. [Citations.] For this purpose and only this purpose, the trust property is treated as the beneficiary's property or as property of the beneficiary's estate." Logically, if trust property belonging to the beneficiary of a special needs trust is treated as the beneficiary's estate only for purposes of government benefits reimbursement, then property placed in Daniel's SNT, which never was his to begin with, and cannot be reached for reimbursement of benefits paid to him on his death, cannot constitute his estate for purposes of reimbursing conservator fees and attorney fees under the Probate Code.

Accordingly, we do not agree that the conservatee's estate included the SNT—which was funded entirely by Roberta's property, not monies or property owned by Daniel. [15]

4. *Nevertheless, the terms of the trust allowed reimbursement for some of the expenditures Patty made on behalf of Daniel and for her conservator fees*

Although we cannot construe the SNT as Daniel's *estate*, the probate court's order directing the trustee to reimburse Patty from the trust for her expenditures and costs incurred on Daniel's behalf was based on the terms of the SNT itself. "The primary duty of a court in construing a trust is to give effect to the settlor's intentions." (*Barefoot v. Jennings* (2020) 8 Cal.5th 822, 826.) Here, the settlor (Roberta) stated her intention clearly. As the court noted, the terms of the trust "clearly show[ed] that the primary use" of the trust's assets—the proceeds from the sale of Roberta's house—"was to provide a supplemental and emergency fund for Daniel" during his lifetime to augment any public benefits available to him.

Under the express terms of the trust, the trustee (Charlyne) was to use the trust income and principal to satisfy Daniel's "special needs"—the "requisites" for maintaining his "good health, comfort, safety, and welfare"—as the trustee in her "sole discretion ... deem[ed] necessary or advisable." The terms of the SNT expressly stated Daniel's special needs "shall include, but not be limited to" his medical and dental care, travel needs, and recreation—among other delineated items—to the extent not provided for or reimbursed by public benefits. Thus, in the court's view, "In a perfect world, Daniel would have lived a much longer life and died spending the last penny of the trust doing something that brought him joy." As the trial court put it, the terms of the SNT "allow[ed] for payment of those 'extras' for Daniel that public benefits did not cover." [16] We agree with the trial court's assessment of the trust instrument.

***13** The court found, "Patty clearly expended monies to afford Daniel a better quality of life both before and after being appointed as his conservator for which reimbursement is now properly claimed." Except for a few categories of expenses that we discuss below, we agree.

Patty prepared a summary of her expenditures she had made for Daniel—both before and after she was appointed his conservator—and gave the court receipts for some, but not all, of them. They included items for Daniel's direct benefit, such as clothing (including underwear), toiletries, dental care, a radio and batteries, grooming services, entertainment, and meals out—items and services that no public benefit program provided for Daniel, would not affect Daniel's eligibility for benefits, and were for Daniel's "good health," "comfort," or "welfare," in accordance with the trust's terms.

Patty also testified about her contact with Daniel and the expenditures she made on his behalf, which the court accurately summarized in its statement of decision. The court noted Patty was concerned Daniel "would end up in a psychiatric hospital." Patty thus maintained regular contact with him after his mother died—after a several year lapse in contact—"so that Daniel had some quality of life that kept him happy and less agitated." She put money on Daniel's account at his facility for extra treats, like "snacks and beverages." The court also noted Patty testified she maintained a journal of the expenses she incurred between July 2016 and July 2020, and had receipts for most of her expenses. And, before the evidentiary hearing, the court noted it had "looked through" the summary of Patty's out-of-pocket costs, as well as the receipts. The court thus had evaluated the documentary evidence supporting the expenses Patty claimed she had incurred on Daniel's behalf, as well as Patty's testimony, to determine Patty legitimately incurred them and they were expended to satisfy Daniel's special needs. Those records and Patty's testimony provide sufficient evidence to support the court's finding that Patty's claimed out-of-pocket expenditures (or, at least, most of them) were appropriate expenditures under the terms of the trust.

Nevertheless, the trust terms gave Charlyne the *sole discretion* to determine what was "necessary or advisable" to pay from the SNT for Daniel's needs. Daniel himself had no right to compel Charlyne to release funds, nor did he have any access to the trust assets. In exercising her sole discretion as trustee, however, Charlyne was required to "act in accordance with fiduciary principles" and could not "act in bad faith or in disregard of the purposes of the trust." (§ 16081, subd. (a); see also Rest.3d Trusts, § 50, subd. (1) ["A discretionary power conferred upon the trustee to determine the benefits of a trust beneficiary is subject to judicial control only to prevent misinterpretation or abuse of the discretion by the trustee."]; *Estate of Giraldin* (2012) 55 Cal.4th 1058, 1072 ["California courts have considered the Restatement of Trusts in interpreting California trust law."].) To determine whether evidence is sufficient to support a trial court's finding that the trustee has "been guilty of an abuse of discretion requires an inquiry into the intentions of the settlor ..., and an examination of the conduct of the trustee[ ] in the administration of the trust." (*In re Ferrall's Estate* (1953) 41 Cal.2d 166, 174.) We conclude substantial evidence supports the court's finding that Charlyne abused her discretion in declining to reimburse (or objecting after Daniel's death to reimbursement of) Patty's expenditures for Daniel's benefit—that were permissible disbursements under the trust—by disregarding the purpose of the SNT. [17]

***14** Charlyne testified Patty shouldn't be reimbursed "[for] a thing" she purchased because Charlyne—or the public guardian when he was the conservator—already had provided Daniel with the same things. Essentially, Charlyne's position was that Patty was making unnecessary, duplicative expenditures without prior authorization.

In her declaration filed in support of her accounting and request for trustee fees, Charlyne averred that, as part of her trustee duties, she had provided Daniel with necessary clothing, cable T.V. to watch sports, money for activities, and whatever else he needed that could be funded from the trust without jeopardizing the public benefits he received. Charlyne's summary of disbursements from the SNT for Daniel's benefit from September 2016 to July 2020 shows payments for Daniel's cable and cellular service, clothing and supplies, shoes, medical care, and "Cash for Daniel Black" (presumably paid to his housing facility for the activities and other needs Charlyne mentioned in her declaration).

From Patty's receipts, it appears she did buy Daniel several apparently duplicative clothing items at times. The court, however, credited Patty's testimony, finding it "credible, thoughtful and unflappable even on cross-examination." The court specifically noted Patty's testimony that she bought extra clothing for Daniel, as he "complained about items going missing in the facility." Patty also testified about having to buy Daniel a new radio because he had broken the two

Charlyne had bought. Thus, we can infer the court rejected Charlyne's position that paying for these duplicate items Patty provided was wasteful or unnecessary.

Substantial evidence also supports the court's finding that Charlyne failed to fulfill her duty under Article 5.4(e) of the trust to "consult with any guardian, conservator, custodian, or other person who cares for [Daniel] regarding his special needs"; and under Article 5.4(b) to "regularly consult with [Daniel] and any persons or entities providing care or assistance to [him] for the purpose of determining [his] needs and resources." As the court noted in its statement of decision, Charlyne admitted she did not confer with or reach out to Patty—even after she was appointed conservator—about "any of Daniel's needs."

Rather, Charlyne testified she "just reached out to the board and care homes" where Daniel lived. She had Patty contact Bunnett.[18] The reason, according to Charlyne, was Patty called her at all hours of the night, leading Charlyne to change her phone number.[19] As a result, Charlyne gave Daniel the number to her cell phone but, because no voicemail had been set up on that phone, he could not leave her a message. Charlyne testified that, if she saw she had missed a call from Daniel, she would call him back.

***15** The court thus could find that Charlyne, having failed to consult Patty regularly about Daniel's needs, at least when she was conservator—and arguably beforehand as a "person[ ] ... providing care or assistance to [Daniel]"—could not reasonably have refused to exercise her discretion to make payments from the SNT to satisfy those needs, as she could not have known what those needs were without consulting Patty. Charlyne apparently did not know Daniel required replacement clothing or other items despite having conferred with his housing facilities. And, Patty testified Daniel could not reach Charlyne by phone. We can infer the court credited this testimony. The court thus could have concluded Charlyne was not regularly asking Daniel about his needs, either.

Accordingly, except for a few categories of costs we discuss below, we conclude the trial court did not err in ordering Patty be reimbursed from the trust for her out-of-pocket expenditures made on Daniel's behalf.

a. *Out-of-pocket attorney fees*

As part of her out-of-pocket costs, Patty asked for reimbursement of attorney fees (and costs) she incurred in 2016 and 2017 with Raxter Law, apparently in connection with or related to the petition she filed in Riverside County that she voluntarily dismissed due to her lack of standing. The record does not demonstrate that Patty's filing of the dismissed petition benefited Daniel in any way. Similarly, she asked for reimbursement of attorney fees incurred in 2017 with Conover & Grebe relating to proceedings in the LPS conservatorship including a hearing on the appointment of the conservator in September 2017. The record does not demonstrate how these attorney fees Patty incurred benefited Daniel either. Accordingly, the court erred in directing the trustee to reimburse Patty from the trust for those out-of-pocket attorney fees.

b. *Cash deposits made before and after appointment as conservator*

Patty's request for reimbursement also included relatively small cash deposits she made on Daniel's account at his housing facility for his "snacks and beverages." Technically, a disbursement from the SNT for Daniel's food could affect his receipt of SSI, as food received by a beneficiary as a result of a disbursement made to a third party is "income in the form of in-kind support and maintenance." (SSA POMS, *supra*, SI 01120.200.E.1.b.)[20] But Charlyne reimbursed herself from the SNT for cash deposits she had made on Daniel's account for his entertainment and other needs. We thus can infer the court found it would be an abuse of Charlyne's discretion not to reimburse Patty as well for those same sorts of expenditures given they were for Daniel's comfort.

On the other hand, Bunnett asked Patty about an ATM withdrawal she had made on November 4, 2019, while she was Daniel's conservator, for $136 that she claimed for reimbursement. Patty testified she had taken that money out of her personal bank account and put it on Daniel's account at his residential care facility for his PNI money.

Patty testified that, "a few times," Daniel's monthly public benefit payments—his social security and SSI—came to her and she put the funds "in the checking account." Patty testified about these funds as Baiden had—that Daniel's monthly social security went to pay for his care at his facility, and his monthly SSI—at either $35 or $136 a month, depending on the type of facility—was put on Daniel's account as his PNI money to pay for "sodas or chips from vending machines or whatever." There was no money left over after making those payments.

***16** As Daniel's monthly SSI either was going to Patty or directly to his facility, there would be no need for Patty to be reimbursed for the $136 she paid for Daniel's PNI. To the extent Patty, as Daniel's conservator, was the named recipient of his SSI, any SSI payments she received, but did not pay to Daniel's account, should be credited back to the trust.

c. *Mileage and transportation costs*

Patty's summary of expenditures for her out-of-pocket costs also included mileage expenses for driving to visit Daniel. Patty's claimed $56,500 in transportation costs—which the court awarded her—represented the cost attributed to the time Patty's husband took to drive Patty to visit Daniel or take Daniel to appointments. Patty's mileage and transportation costs included trips she made to visit Daniel before and after she became his conservator.

Patty's husband Earl drove her because she did not drive long distances. For a time, Patty did not live close to Daniel's facilities. According to her records, which the court credited, she drove 110 to 168 miles roundtrip to see Daniel. Earl testified it was five hours roundtrip from their residence in Lake Elsinore to the locations of Daniel's residence and health appointments, which until fall 2019, were in places like Sylmar, Santa Monica, Downey, and Los Angeles. Earl "charged" $400 per roundtrip to these places.[21] He based that figure on the $400 Charlyne paid a third party, who also cut Daniel's hair, to drive her to visit Daniel. She paid her daughter $300 to drive her. (Charlyne was about 79 years old.) Earl testified he also helped Patty with Daniel during her visits—for example, supervising him in public restrooms. Baiden agreed it was necessary to have more than one person transport Daniel anywhere due to his behavior. The court found Patty's husband's and Baiden's testimony credible.

As Daniel's conservator, Patty had a duty to visit him and attend to and assess his needs. Had Daniel had an estate, she would have been entitled to recover "reasonable expenses incurred in the exercise of the powers and the performance of the duties of ... conservator." (§ 2623, subd. (a)(1).) This evidence supports the trial court's finding that Patty's transportation costs—once she became Daniel's conservator—were reasonable.[22] Moreover, Patty's performance of her duties as conservator were for Daniel's direct benefit. Because she had to drive a long distance to see Daniel, and could not transport him in the car alone,[23] she could not have performed those duties without Earl's services. Accordingly, the court reasonably could find it would be an abuse of discretion for the trustee not to reimburse Patty for these expenses incurred in the course of performing her conservator duties for Daniel.[24]

***17** Before she was appointed Daniel's conservator, however, Patty—and her husband—sat in the position of an aunt and uncle visiting their disabled nephew. And, unlike the items Patty purchased for Daniel or entertainment she provided for him, Patty's mileage and transportation costs did not *directly* benefit Daniel. We thus cannot conclude Charlyne can be deemed to have abused her discretion by not reimbursing, or objecting to reimbursing, Patty for her mileage or transportation costs in making those voluntary, though thoughtful, visits. Paying for Patty's mileage and husband-driver was not necessary to Daniel's comfort or welfare, as was—say—buying him clothing to replace what had "gone missing." Thus, the court had no basis to order the trust to pay for those expenses.

d. *Other pre-conservator personal expenses*

We also do not agree the SNT required Charlyne to reimburse Patty for her other personal expenses—such as her own (and Earl's) meals and entertainment costs—incurred during visits to Daniel before Patty became his conservator. Patty was Daniel's aunt. We cannot conclude Daniel's mother intended the SNT to be used to pay for her sister's meals and entertainment simply because she incurred those costs while visiting her nephew. (*In re Greenleaf's Estate* (1951) 101 Cal.App.2d 658, 661–662 ["the basic inquiry, whenever the exercise of a trustee's discretion, absolute or otherwise, is challenged, is always whether the trustee acted in the state of mind contemplated by the trustor"].) As with her pre-conservator transportation costs, Patty's or Earl's own food purchases, movie tickets, and the like did not "supplement" Daniel's public benefits—the SNT's stated purpose—unlike the items, services, and entertainment Patty purchased *for* Daniel. Once Patty replaced the public guardian as Daniel's conservator, however, the county no longer provided Daniel with conservator services. Accordingly, reasonable expenses Patty incurred in discharging the duties she owed Daniel as his court-appointed conservator—as with her conservator fees discussed below—necessarily were for Daniel's welfare.[25]

e. *Conservator fees*

The court found Patty's claimed conservator fees of $8,000—billed at an hourly rate less than what Charlyne billed for her trustee fees—was "more than reasonable and should be

allowed." The trust allows payment of trustee fees but is silent as to the payment of conservator fees. The court reasonably could conclude that was the case because the public guardian was Daniel's conservator when Roberta executed the restated trust, which included the SNT. As the public guardian remained Daniel's conservator, there would have been no reason for Roberta to amend her trust to add a provision specifically allowing for the payment of conservator fees. In any event, Patty's performance of her duties as Daniel's court-appointed conservator necessarily were required for Daniel's welfare. Accordingly, the court did not err in directing the trust to pay Patty's conservator fees.

5. ***Attorney fees***

Finally, the court awarded Cohan his requested costs of $1,097.26 from the trust, finding he incurred them "while seeking relief that was to benefit Daniel [and] for which the trust should be obligated to pay." The court also found Cohan's "attorney fees were generated in response to the litigation tactics of Charlyne and her counsel," including having to respond to Bunnett/Charlyne's opposition to releasing the funds for Daniel's dental work, responding to Bunnett's lengthy discovery requests, and apparently attending a six-hour deposition of Patty. The court, however, was "not persuaded" that all of the $36,925 in fees Cohan requested "went to benefit Daniel and/or the trust." The court found $27,850 was a reasonable amount of attorney fees the trust should pay Cohan.

***18** The mental health court appointed Cohan as Patty's counsel under section 5370.1 of the Welfare and Institutions Code—part of the LPS Act—entitled "[a]ppointment of counsel for private conservator with insufficient funds." That section provides the court "may appoint ... a private attorney to represent a private conservator *in all proceedings connected with the conservatorship*, if it appears that the conservator has insufficient funds to obtain the services of a private attorney." (Welf. & Inst. Code, § 5370.1, italics added.) We presume the court found Patty had insufficient funds to pay for counsel as it ordered the county was to pay attorney fees.

Cohan represented he was appointed to represent the conservator for all purposes—that would include representing Patty in the probate proceeding. The probate matter undisputedly was connected with the conservatorship matter. The mental health court ordered that the reasonableness of the dental treatment for Daniel, including its cost, should be determined by the probate court where the section 17200 petition was pending. Patty's efforts in the probate court to obtain the trust funds for Daniel's dental work were in performance of her duties as his conservator. Accordingly, it seems the mental health court's order applies to Patty's attorney fees incurred in the probate court to secure the $30,000 disbursement for Daniel's dental treatment. In other words, as the mental health court ordered, the county should pay for that portion of Patty's attorney fees.

In a supplemental filing, Cohan stated he had not filed his fee request with the mental health court for his representation of Patty in the probate court because the presiding judge there told him those "services ... related to counsel's appointment in the non-LPS probate case ... and therefore the fee request should not be presented to the mental health court."[26] As Cohan's only court appointment comes from the mental health court's order, the terms of that order would seem to apply in the probate court as well. We remand the matter for the probate court to determine whether the county, in accordance with the mental health court order, should pay for that portion of Patty's attorney fees incurred in obtaining the funding for Daniel's dental treatment in the probate court.

However, we do not agree that the fees Cohan generated representing Patty in her petition for reimbursement of *her* costs and fees from the trust were for *Daniel's* benefit. Accordingly, we do not see a basis for the court ordering the trust to pay those fees.

Just as the trust is silent as to the payment of conservator fees, it also is silent as to the payment of attorney fees for anyone other than the trustee. Again, the public guardian was Daniel's conservator when Roberta executed the SNT and at her death. The public guardian would not have been entitled to attorney fees from the SNT. Patty argues Article 5.4(c) "specifically provides ... 'reasonable attorneys' fees' 'shall be a proper charge to the trust estate' in the event of litigation." That section, however, refers only to the *trustee's* attorney fees. The terms of the trust required the trustee to deny any request to release funds to pay for needs that public benefits would be authorized to provide, and to "take whatever administrative or judicial steps may be necessary to continue the eligibility of [Daniel] for all available public benefits." The paragraph ends, "Any expenses of the trustee in this regard, *including reasonable attorneys' fees*, shall be a proper charge to the estate." (Italics added.) It is disingenuous for Patty to imply this provision of the trust authorizes the conservator's attorney fees.

***19** As there is no express provision authorizing payment of Daniel's conservator's attorney fees, we cannot find Charlyne's objection to payment of those attorney fees incurred to recover funds for Patty is an abuse of the trustee's discretion. Accordingly, on remand, the court should determine what portion of Cohan's attorney fees were incurred in prosecuting Patty's petition to recover her conservator fees, expenses, and attorney fees from the trust and exclude them.

6. ***There was no irregularity in the proceedings resulting in a miscarriage of justice***

Charlyne argues the irregularity in the proceedings caused a miscarriage of justice. Charlyne's chief complaint, as it was in her motion for new trial, is that the trial court abused its discretion in not conducting the bench trial in open court. Charlyne and her counsel appeared in person on the first day of the evidentiary hearing on October 20, 2021, but Patty, Cohan, and the GAL appeared remotely through Court Connect. (Patty appeared by phone only.) Bunnett asked for a continuance, arguing his presentation of the evidence would be hampered as he had been prepared to question the witnesses using exhibits in an exhibit book. The court denied the continuance, noting the court allows parties to appear in person or remotely, depending on their comfort level with what then was an ongoing pandemic. Although the minute order setting the October 20, 2021 hearing date does not mention remote appearances, the court's order denying the new trial motion stated, "During the Court's trial setting conference, the Court authorized the parties to either appear remotely or in person for the upcoming trial."

Charlyne argues the court failed to give proper notice of the remote appearance under section 367.75 of the Code of Civil Procedure and rule 3.672 of the California Rules of Court. Even if we assume there was no notice, Charlyne has failed to show how she was prejudiced. The court began the hearing with Patty's petition. On a break, Bunnett was able to send his exhibits to the parties and counsel through a DropBox link, and they were able to open the exhibits and answer his questions about them. There was no miscarriage of justice.

Charlyne contends a miscarriage of justice occurred based on several other grounds, including that the court prejudged the evidence; attempted to coerce Bunnett to stipulate to Patty's claimed costs; did not allow Bunnett to develop a defense to Patty's and her counsel's accusations that Charlyne did nothing for Daniel's dental work; excluded exhibits Bunnett had prepared to reorganize and categorize the receipts Patty submitted; and there were purported inaccuracies in the statement of decision. We find none of Charlyne's contentions has merit, nor has she demonstrated how any of them led to an unfair trial.

There is no evidence the court engaged in any misconduct. The parties submitted written argument and evidence in advance of the bench trial. The court did not prejudge the evidence. The court gave the parties its tentative ruling on some of the fees and costs claimed—after reviewing the parties' submissions—and noted it was inclined to grant Patty's request for reimbursement of about $33,200 but probably would "need some further testimony or elaboration" on the $56,500 she claimed in transportation costs. The court did not state it was inclined to exclude those expenses or ask Bunnett to stipulate to the $56,500 as Charlyne asserts. As to the $33,200 in costs, the court merely asked Bunnett if he wanted to submit on that figure. After Bunnett argued about certain items, the court noted it would be a "long slog" to go line-by-line, and the court would take that into account "in terms of any fees I make for anybody." We read the court's comments as trying to streamline the presentation of evidence and letting counsel know the court would not be inclined to find counsel's time reasonably spent for purposes of recovering fees if they were to go through each expenditure, line by line over several pages. In any event, neither Bunnett nor Cohan was awarded all the fees they requested.

***20** As for the evidence, the court acted within its discretion to exclude Bunnett's duplicative exhibits of Patty's costs. (See Evid. Code, § 352.) And, based on our review of the record, Charlyne was able sufficiently to develop her case. Moreover, some of the evidence, or lack thereof, about which she complains is more relevant to the court's orders awarding her trustee fees and attorney fees, which she does not challenge on this appeal. We find no prejudicial error.

7. ***The court's sanction award***

In denying Charlyne's motion for new trial, the court awarded sanctions of $1,750 against Charlyne and her attorney, jointly and severally, to be paid out of her share of the trust directly to Cohan (for having to prepare his opposition). The court's September 2, 2022 minute order does not state the basis for the sanctions.

In his joint opposition to Charlyne's motions, Cohan invited the court to issue an order to show cause as to why Bunnett had not violated Code of Civil Procedure section 128.7 in filing his motions. Under section 128.7, subd. (c)(2), the court

may, on its own motion, issue an order to show cause as to why an attorney should not be sanctioned for presenting a pleading or motion for an improper purpose, or without basis in law or fact. There is no such order to show cause in the appellate record. Accordingly, we presume the court did not issue sanctions under that statute.

Appellant's opening brief argues "[t]he fact the motion lacks merit is not enough by itself to justify an award of Code of Civil Procedure § 128.5 sanctions." (Respondent's brief provides no legal citation regarding sanctions.) Under Code of Civil Procedure section 128.5, a trial court may order a party and the party's attorney to pay "the reasonable expenses, including attorney's fees, incurred by another party as a result of actions or tactics, made in bad faith, that are frivolous or solely intended to cause unnecessary delay." (Code Civ. Proc., § 128.5, subd. (a).) " 'Frivolous' means totally and completely without merit or for the sole purpose of harassing an opposing party.' " (*Id.*, subd. (b)(2).)

At the hearing on Charlyne's motion, the court found the remote appearance issue discussed above was not "a meritorious basis" for bringing a motion for new trial under section 657 of the Code of Civil Procedure for a trial irregularity. Based on our discussion above, and the court's comments at the motion hearing and in its minute order, we conclude the court found the new trial motion frivolous. We agree. Nevertheless, to award sanctions under section 128.5, the court had to find the motion was frivolous *and* in bad faith. (See, e.g., *Shelton v. Rancho Mortgage & Investment Corp.* (2002) 94 Cal.App.4th 1337, 1346.) The court did not make such a finding. We thus reverse the sanctions order.

DISPOSITION

The court's September 2, 2022 order awarding $1,750 in sanctions against appellant and her counsel is reversed. The court's June 24, 2022 "order re petition for allowance of conservator fees, reimbursement of costs advanced and incurred and conservator's attorney's fees and costs" is affirmed in part and reversed in part. The matter is remanded for the court to conduct further proceedings consistent with this opinion, as follows.

The court shall recalculate the amounts ordered to be reimbursed to Patty Wiedner from the SNT (1) to reduce the $32,198.36 reimbursement by (a) any cash deposits Patty made to Daniel's facilities for his PNI to the extent those amounts were covered by Daniel's monthly SSI payments that Patty received but did not pay to Daniel's facilities; (b) "auto allowance" (mileage) costs claimed for dates before April 10, 2019; (c) "auto allowance" (mileage) costs for dates on or after April 10, 2019, on which Patty also asked to be reimbursed for transportation costs; (d) any out-of-pocket costs incurred before April 10, 2019 to pay for the meals or food, entertainment expenses, items, services, etc. of anyone other than Daniel Black; and (e) attorney fees (and any related costs) paid to Raxter Law in 2016 and 2017 and to Conover & Grebe in 2017; and (2) to reduce the $56,500 transportation costs reimbursement by the amount claimed for dates before April 10, 2019. The $8,000 conservator fee reimbursement is affirmed.

***21** With respect to the $28,947.26 in attorney fees and costs ordered to be reimbursed from the SNT to Patty's court-appointed attorney John Cohan: (1) the court shall determine whether Los Angeles County should pay—under the terms of the mental health court's December 6, 2019 order—Patty's attorney fees incurred to obtain funding from the SNT for Daniel's dental work, and if so, order the County, rather than the SNT, to reimburse Cohan for those fees; and (2) if the court determines the County is not responsible to reimburse Cohan, the court shall reduce the $28,947.26 reimbursement from the SNT by the amount of attorney fees incurred to prosecute Patty's petition to recover her conservator fees, expenses, and attorney fees from the SNT.

The court also shall amend paragraph (2)(a) on page two of its July 1, 2022 order to direct the Trustee to pay the amounts as recalculated on remand.

The parties are to bear their own costs on appeal.

We concur:

LAVIN, Acting P. J.

ADAMS, J.

All Citations

Not Reported in Cal.Rptr., 2024 WL 2125657

Footnotes

1 We refer to Roberta, Daniel, Charlyne, and Patty by their first names for ease of reference. We intend no disrespect in doing so.

2 A special needs trust is a trust that is intended to allow the beneficiary to continue to maintain eligibility for certain needs-based government benefits. (*Balian v. Balian* (2009) 179 Cal.App.4th 1505, 1512.) Daniel's needs-based government benefits were his monthly supplemental security income (SSI) and Medi-Cal benefits.

3 The LPS Act (Welf. & Inst. Code, § 5000 et seq.) provides for the appointment of a conservator of the person, the estate, or both, "for a person who is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism." (*Id.*, § 5350.)

4 Baiden was a deputy public conservator with the office of the public guardian. The public guardian must serve as conservator of any person found to be gravely disabled under the LPS Act for whom the court has recommended a conservatorship "if the court finds that no other person or entity is willing and able to serve as conservator." (Welf. & Inst. Code, § 5354.5.)

5 The SNT defines "public benefits" as including, but not limited to, SSI, Medi-Cal or other state medical assistance program authorized under Medicaid, and federal social security disability insurance.

6 In April 2017, Patty apparently filed a petition in the Riverside County superior court asking it to monitor the SNT. After Charlyne (through Bunnett) filed a demurrer based on Patty's lack of standing, Patty withdrew her petition. Patty's petition is not part of the appellate record.

7 Lumina Dental, however, prepared an estimate that focused on removing only the four worst teeth. The public guardian paid for that treatment in advance—about $3,600—from Daniel's monthly benefits. Daniel was unable to have the procedure at that time due to his instability. By the time he was able, the public guardian no longer was conservator.

8 Statutory references are to the Probate Code, unless otherwise stated.

9 Patty filed a notice of related case, which Charlyne opposed. Because the LPS conservatorship case and the new probate case both fell within the probate division rules, Department 1 did not relate them.

10 The Medi-Cal Dental Provider Handbook required pre-authorization for dental implants and documentation of "exceptional medical circumstances."

11 At the hearing, the court stated that, if Patty planned to seek reimbursement for any expenses, "that should be something that is brought before the court."

12 More specifically, Charlyne contends the court erred in "imposing an equitable lien against the vested interest of the [trust's] contingent beneficiaries in contravention to the express intentions of the settlor of [Roberta's trust]."

13 Charlyne contends Patty did not file her petition in her capacity as Daniel's conservator. By the time Patty filed her petition, Daniel's conservatorship had terminated due to his death. (§ 1860, subd. (a).) Section 2630 allows the court to retain jurisdiction of the conservatorship proceeding in the event of the conservatee's death for the purpose of settling the accounts of the conservator "or for any other purpose incident to the enforcement of the judgments and orders of the court." As Charlyne notes, the probate court did not have jurisdiction over the conservatorship case; the mental health court did. Nevertheless, as Patty would have

been able to file her petition as Daniel's conservator had he not died, she did not lose standing to ask the probate court for reimbursement from the trust in connection with Charlyne's petition that brought the trust under the court's jurisdiction. Again, Patty's request relates to the court's consideration of Charlyne's exercise of her discretionary powers and her accounting as trustee. Moreover, the first paragraph of Patty's petition states she was appointed conservator of the person of Daniel, the "deceased beneficiary of the [SNT] subject to this proceeding," and Cohan identifies himself as the "court-appointed counsel for Patty Wiedner, Conservator of Daniel Lee Black, Conservatee." Accordingly, Patty was bringing her petition in her capacity as Daniel's conservator up until his death.

14 Section 2640 governs petitions to the court by conservators of the *estate* for an "order fixing and allowing compensation." (§ 2640, subd. (a).) Patty was appointed conservator of the person only.

15 In its order denying Charlyne's motion to set aside the judgment, the court found section 2640.1 provided that "the conservatorship fees and attorney's fees may be paid from the Living Trust as the Probate Code broadly defines 'estate' as a conservatee's 'personal property, wherever located, and real property located in this state.' " (Quoting § 2400.) It's unclear why the court relied on section 2640.1. That section authorizes a person who petitioned for appointment as conservator, but who was not appointed in lieu of a different conservator, to petition the court for compensation for "his or her services rendered in connection with and to facilitate the appointment of a conservator, and costs incurred in connection therewith." (§ 2640.1, subds. (a) & (c).)

16 Indeed, an SNT can make disbursements for many services and items not covered by public benefits without affecting the beneficiary's eligibility for Medicaid and SSI—the need-based public benefits Daniel received—such as: entertainment; recreation; vacations; caregiving; cell phone, cable, or internet services; electronics; clothing; hair care; hobby supplies; magazine and newspaper subscriptions; nonfood grocery items; over the counter medications; and many others. (See Cal. CEB, Special Needs Trusts: Planning, Drafting, and Administration (2023) § 14.67.5 [list of "generally permissible distributions"] (CEB, Special Needs Trusts). Disbursements for food and shelter, however, are considered income that could reduce the amount of SSI the beneficiary receives. (Social Security Administration, Program Operations Manual System —Supplemental Security Income (May 2024) SI 01120.200.E.1.b. <https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200> [as of May 10, 2024], archived at <https://perma.cc/ME6Q-GECJ> (SSA POMS) ["[f]ood or shelter received by the trust beneficiary as a result of disbursements from the trust to a third party is income in the form of in-kind support and maintenance"]; Hook, *supra*, § 9.01[D][2] ["[a]ll distributions should be made to third parties on behalf of the beneficiary and should be limited, to the extent possible, to items that cannot be considered food or shelter, or converted to use for food or shelter," which are considered income, citing SSA POMS, *supra*, SI 01120.200.E.1.a & 01120.200.E.1.b]; see also Handbook, *supra*, pp. 10–12 [similar].) The occasional meal out "may be characterized as entertainment" rather than food, however. (CEB, Special Needs Trusts, *supra*, § 14.53.)

17 In considering what amount of trustee fees to award Charlyne, the court also found she "breached her duties as trustee not only as described in the trust document itself but also within the meaning of [§] 16004," which deals with conflicts of interest. The court found "Charlyne had a very high duty to make sure that her decision making and actions did not result in deprivation of trust assets for Daniel's use which would necessarily result in a larger amount being distributed to her upon his death."

18 The court also reasonably could find Charlyne's delegation to Bunnett was not effective. Patty's former court-appointed attorney Stanford told the court, at the July 31, 2020 hearing, that she had written to Bunnett in July 2019 about arranging for any court-approved dental treatment for Daniel and to establish a budget out of the SNT for Daniel's recreational and entertainment needs. Bunnett apparently responded with a letter "that was basically a treatise on special needs trusts, and from that point," he never responded to Stanford's emails or voicemails.

19 When the court directly asked Charlyne, “Why didn't you reach out to your sister as was your responsibility as trustee?” Charlyne replied, “Because Danny kept telling me she didn't like him.”

20 Similarly, Patty asked for reimbursement for food she purchased for Daniel at grocery stores, such as cereal or juice. We can infer the court concluded either these extra treats were more along the lines of entertainment than food—as Daniel's housing facility provided his food—or the value of any snacks or beverages purchased would have been too small to make a real difference in Daniel's receipt of SSI had he lived.

21 Patty did not actually pay her husband for driving her.

22 As she does on appeal, Charlyne argued “travel and mileage by a conservator is generally not reimbursable” under rule 4.43 of the Los Angeles Superior Court Local Rules. That rule does not allow a personal representative to claim “[l]ocal travel and mileage” as costs, but does allow claimed costs for long distance travel. (Rule 4.43(a)(5) & (b)(3).)

23 Patty testified she had to sit in the backseat with Daniel to prevent him from bolting from the car.

24 Nevertheless, the record does not support requiring the SNT to pay Patty her requested “auto allowance” (mileage) at $.55 per mile for trips where she also claimed transportation fees for Earl's driving “services.” Earl testified he and Patty thought a $400 flat rate was reasonable as Charlyne paid that amount for Michelle Higgens (a “beauty operator”) to drive her. (Earl “charged” $100 after Daniel moved to a facility in their own county.) Charlyne did not also reimburse herself—or her drivers —for separate mileage fees, however. As Earl based his fees for driving Patty on what Charlyne had paid, his $400 (and $100) trip rates also presumably accounted for mileage. At oral argument, Cohan could not say what the fees included. Accordingly, any mileage expenses Patty claimed during her tenure as conservator for trips where she also claimed a transportation fee should be excluded as duplicative.

25 Patty notes section 2641 authorizes the court to include in an order of conservator fees compensation for a conservator's services “rendered before the date of the order appointing the ... conservator.” (§ 2641, subd. (b).) As we discussed, such compensation must be charged against the conservatee's estate, and the SNT is not part of Daniel's estate.

26 Cohan also said he had been paid for work he had done representing Patty in the mental health court.

2024 WL 2150288
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of Connecticut,
JUDICIAL DISTRICT OF NEW LONDON.
AT NEW LONDON.

Deborah C. STORY,
v.
Benjamin CARBONE, Jr, et al

DOCKET NO: KNLCV226059019S
|
MAY 10, 2024

MEMORANDUM OF DECISION

James Field Spallone, Judge, Connecticut Superior Court

INTRODUCTION

***1** This matter, tried to the court, presently comes before the court on the Defendant's Motion for Directed Verdict and/or Post-trial Brief and the Plaintiff's Post-trial Memorandum. (Docket Entry Nos. 143 and 144.) The Defendant contends that he is entitled to judgment on all six counts of the Plaintiff's Complaint on the grounds that: (1) the underlying contract between the Plaintiff and the Defendant is void as against public policy; (2) the parties' agreement is void by operation of the statute of frauds and (3) the Plaintiff has failed to demonstrate that there was an agreement between herself and the Defendant. For the reasons set forth below, the court will treat the motion filed by the Defendant as a motion for judgment of dismissal judgment under Practice Book § 15-8, and hereby grants that motion.

RELEVANT FACTS AND PROCEDURAL HISTORY

On October 24, 2022, the Plaintiff, Deborah C. Story, commenced this action by service of process against the Defendant Benjamin Carbone, Jr. [1] In the operative pleading, the Amended Complaint filed on November 8, 2023 (Docket Entry No. 133), the Plaintiff alleges the following facts. All of the facts relevant to the disposition of the Defendant's motion and this case are uncontroverted. Anne Carbone (Carbone) was the mother of both the Plaintiff and the Defendant, and she owned certain real property located at 7 Lee Road in Waterford (the property). On October 4, 2019, Carbone executed a last will and testament. According to this document, upon her death, the property was to be sold and the proceeds equally divided among the Plaintiff, the Defendant, and four of Carbone's other children, Paula Crabb, Jackie Carbone Dorsey, [2] Karen (Lisa) Bowens, and Thomas Carbone (collectively, the siblings). Subsequently, on February 8, 2020, Carbone, in the presence of witnesses, entered into an oral agreement with the Defendant. As part of this purported contract, Carbone agreed to transfer the property to the Defendant for no consideration such that in the event Carbone needed long-term care, the property would be protected for her children to inherit. The Defendant, in turn, would be allowed to live on the property rent free and he agreed that upon Carbone's death, he would transfer and/or sell the property in equal shares to all of Carbone's children. [3]

***2** To that end, on February 11, 2020, Carbone executed a quit claim deed conveying her interest in the property to the Defendant. This deed was recorded on the Waterford land records. Thereafter, on February 26, 2020, [4] the Defendant executed a last will and testament that provided that the property was to be sold and the proceeds distributed among the Defendant's son (Benjamin P. Cabone, III), the Plaintiff, and the siblings. The purpose of this will was to ensure that the property was to be divided in accordance with Carbone's wishes. On November 24, 2020, Carbone passed away. Following Carbone's death, on June 17, 2021, the Defendant executed a new will and testament that only left the property to his son and excluded the Plaintiff and the siblings. The Plaintiff alleges that Carbone relied on the Defendant's oral agreement when she transferred the property to the Defendant. Despite the Defendant's acknowledgment of the agreement, the Defendant refuses to sign a deed transferring his ownership to the Plaintiff and his siblings. According to the Plaintiff, the Defendant is wrongfully taking the position that he is the sole owner of the property.

As a result of all of this alleged conduct, the Plaintiff brings the following causes of action against the Defendant: (1) count one—motion to determine title in accordance with General Statutes § 47-31; (2) count two—partition as to the property pursuant to General Statutes § 52-495 et seq.; (3) count three—breach of contract; (4) count four—unjust enrichment; (5) count five—tortious interference with the expectation of an inheritance; and (6) count six—constructive trust. In his answer (Docket Entry No. 139), the Defendant alleges the following special defenses: (1) contract void

as illegal; (2) contract void as a matter of public policy; (3) statute of frauds; (4) unjust enrichment impermissible under public policy; (5) invalid cause of action; (6) wrongful conduct rule; and (7) unclean hands.

The parties appeared on December 15, 18, and 21, 2023, for a court trial. Following the proceedings, the court ordered simultaneous post-trial briefs to be filed within forty-five days. On February 5, 2024, the Defendant filed a "Motion for Directed Verdict and/or Post-trial Brief" (Docket Entry No. 143) and the Plaintiff filed a post-trial memorandum (Docket Entry No. 144). The court heard oral argument on these pleadings on February 15, 2024.

DISCUSSION

Nature of Issue Before the Court

As a threshold issue, the court must determine whether the Defendant's arguments are appropriately before it as a motion for directed verdict. Under Connecticut law, "[a] trial court should direct a verdict only when a *jury* could not reasonably and legally have reached any other conclusion.... In reviewing the trial court's decision [to grant a Defendant's motion for a directed verdict] [an appellate court] must consider the evidence in the light most favorable to the Plaintiff.... A directed verdict is justified if ... the evidence is so weak that it would be proper for the court to set aside a *verdict* rendered for the other party." (Emphasis added; internal quotation marks omitted.) *Farrell* v. *Johnson & Johnson*, 335 Conn. 398, 417, 238 A.3d 698 (2020). This language plainly suggests that a court may only direct a verdict within the context of a jury trial. This conclusion is supported by the applicable Practice Book provision which provides, in relevant part, that "[w]henever a motion for a directed verdict made at any time after the close of the Plaintiff's case-in-chief is denied or for any reason is not granted, the judicial authority is deemed to have submitted the action *to the jury* ...." (Emphasis added.) Practice Book § 16-37; see also *State* v. *Morrison*, 2 Conn. Cir. Ct. 443, 445, 200 A.2d 737 (1963) (stating, that with respect to a motion for direct verdict, "[n]o such motion lies in a trial to the court").

The rules of practice specifically authorize an analogous procedure to a directed verdict motion for civil court trials. Practice Book § 15-8 provides in relevant part: "If, on the trial of any issue of fact in a civil matter tried to the court, the plaintiff has produced evidence and rested, a defendant may move for judgment of dismissal, and the judicial authority may grant such motion if the plaintiff has failed to make out a prima facie case." In order for this practice book provision to apply, "[a] motion for judgment of dismissal must be made by the defendant and decided by the court after the plaintiff has rested his case, but before the Defendant produces evidence." (Emphasis omitted; internal quotation marks omitted.) *Moutinho* v. *500 North Avenue, LLC*, 191 Conn. App. 608, 618, 216 A.3d 667, cert. denied, 333 Conn. 928, 218 A.3d 68 (2019). In the present matter, after the Plaintiff rested her case, the Defendant did not present any evidence. Rather, the Defendant indicated that he intended to make appropriate legal arguments in his post-trial brief. Therefore, although the Defendant has not directly cited to § 15-8, the court will construe the Defendant's motion as being filed under that section of the rules of practice because "[w]here a party captions its motion improperly, [a court] look[s] to the substance of the claim rather than the form." (Internal quotation marks omitted.) *Machado* v. *Taylor*, 326 Conn. 396, 402, 163 A.3d 558 (2017); see, e.g., *Office of Chief Disciplinary Counsel* v. *Miller*, Superior Court, Judicial District of Danbury, Docket No. CV17-6022075-S (November 26, 2018, *Shaban, J.*), aff'd and reprinted at 335 Conn. 474, 499 n.7, 239 A.3d 288 (2020) (wherein the court applied § 15-8 even though it had not been cited by the movant); *Eady* v. *Cowles*, Superior Court, Judicial District of Waterbury, Docket No. CV09-5014356-S (June 4, 2013, *Sheedy, J.T.R.*) (stating, in a court trial, that "[d]efendant's [m]otion for [d]irected [v]erdict is properly a [m]otion for [j]udgment of [d]ismissal under ... § 15–8").

***3** "The standard for determining whether the Plaintiff has made out a prima facie case, under Practice Book § 15-8, is whether the Plaintiff put forth sufficient evidence that, if believed, would establish a prima facie case, not whether the trier of fact believes it.... For the court to grant the motion [for a judgment of dismissal pursuant to § 15-8], it must be of the opinion that the Plaintiff has failed to make out a prima facie case. In testing the sufficiency of the evidence, the court compares the evidence with the allegations of the Complaint.... In order to establish a prima facie case, the proponent must submit evidence, which, if credited, is sufficient to establish the fact or facts which it is adduced to prove.... [T]he evidence offered by the Plaintiff is to be taken as true and interpreted in the light most favorable to [the Plaintiff], and every reasonable inference is to be drawn in [the Plaintiff's] favor." (Internal quotation marks omitted.) *Briarwood of Silvermine, LLC* v. *Yew Street Partners, LLC*, 209 Conn. App. 271, 278, 267 A.3d 905 (2021). The court will examine each of the arguments raised by the Defendant with this standard in mind.

Legality and Public Policy Considerations of the Alleged Contract

The Defendant first argues that the purported oral contract between the Defendant and Carbone to hold the property in trust and then reconvey it to the Plaintiff and her siblings upon Carbone's death is void as against public policy. According to the Defendant, the objective of this agreement was to work around Medicaid by sheltering the property from being considered one of Carbone's assets that determined her Medicaid eligibility. It is the Defendant's position that although the original conveyance of the property from Carbone to the Defendant was legal because transfers of property to a disabled son or daughter are exempt from the reach of Medicaid, the subsequent agreement to transfer the property back is legally unenforceable. On this basis, the Defendant contends that he is entitled to judgment in his favor.

In response, the Plaintiff asserts that this argument must fail because neither the state of Connecticut nor the federal Medicaid program was defrauded. Rather, according to the Plaintiff, the transfer of the property was properly disclosed, and Carbone was only on Medicaid for an approximately five-month period. The Plaintiff also contends that Carbone's estate fully repaid and satisfied the Medicaid lien. [5] Additionally, the Plaintiff argues that Carbone did not deceive anybody, and that Carbone relied on the advice of counsel with respect to Medicaid eligibility and the relevant property transfers. Finally, the Plaintiff asserts that this matter is similar to cases where Connecticut courts have held that equity demands the creation of a constructive trust.

"The [Medicaid] program, which was established in 1965 as Title XIX of the Social Security Act and is codified at 42 U.S.C. § 1396 et seq.... is a joint federal-state venture providing financial assistance to persons whose income and resources are inadequate to meet the costs of, among other things, medically necessary nursing facility care.... The federal government shares the costs of [M]edicaid with those states that elect to participate in the program, and, in return, the states are required to comply with requirements imposed by the [M]edicaid [A]ct and by the [S]ecretary of the Department of Health and Human Services." (Internal quotation marks omitted.) *Pikula* v. *Dept. of Social Services*, 321 Conn. 259, 264, 138 A.3d 212 (2016). "One of those provisions is the asset transfer provision in 42 U.S.C. § 1396p. Section 1396p (c) (1) imposes a period of ineligibility, generally called the penalty period, on persons who dispose of their assets for less than fair market value within [thirty-six] months before their application for long-term care benefits." *Croll* v. *Commissioner of Dept. of Social Services*, Superior Court, Judicial District of New Britain, Docket No. CV17-6035934-S (February 23, 2018, *Huddles ton, J.*).

***4** "Connecticut's Medicaid plan implements the requirements of 42 U.S.C. § 1396p (c) (1) through several statutes and regulations." Id. General Statutes § 17b–261 (a) provides in relevant part that "[m]edical assistance shall be provided for any otherwise eligible person ... if such person ... has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance" under the Medicaid program. Additionally, General Statutes § 17b–261a (a) provides that any transfer of assets with the penalty period before applying for medical assistance "shall be presumed to be made with the intent ... to obtain or maintain eligibility for medical assistance. This presumption may be rebutted only by clear and convincing evidence that the transferor's eligibility or potential eligibility for medical assistance was not a basis for the transfer or assignment."

When passing the Medicaid program, Congress demonstrated a "legislative concern that the [M]edicaid program not be used as an estate planning tool. The [M]edicaid program would be at fiscal risk if individuals were permitted to preserve assets for their heirs while receiving [M]edicaid benefits from the state. [Accordingly, Medicaid's] ... provisions [were] designed to assure that individuals receiving nursing home and other long-term care services under Medicaid are in fact poor and have not transferred assets that should be used to purchase the needed services before Medicaid benefits are made available." (Internal quotation marks omitted.) *Forsyth* v. *Rowe*, 226 Conn. 818, 828-29, 629 A.2d 379 (1993). Simply put, "[t]he federal statutes illustrate that Congress has mandated that [M]edicaid be a payer of last resort ...." (Internal quotation marks omitted.) *Rathburn* v. *Health New of the Northeast, Inc.*, 315 Conn. 674, 686, 110 A.3d 304 (2015). To that end, "[a] person who has income or assets above those limits must 'spend down' those resources to become eligible for Medicaid long-term care benefits." *Rathburn* v. *Commissioner of Dept. of Social Services*, Superior Court, Judicial District of New Britian, Docket No. CV15-6028667-S (June 16, 2017, *Huddleston, J.*).

Although the parties agree that the initial transfer of the property from Carbone to the Defendant was not prohibited

by federal law because the Defendant was Carbone's disabled son; 42 U.S.C. § 1396p (c) (2) (A) (ii)[6]; it is apparent that the overall objective of that transfer, and the alleged agreement for the Defendant to reconvey the property upon Carbone's death, was to thwart—or would reasonably be expected to have the effect of thwarting--Medicaid's statutory scheme. Indeed, in paragraph seventeen of her Complaint, the Plaintiff alleges that pursuant to the February 8, 2020 oral agreement between Carbone and the Defendant, Carbone was to "transfer her home ... to [the Defendant] for no consideration so in the event that ... Carbone needed long term care, the property would be protected for her children to inherit." Moreover, the Plaintiff's testimony at trial explicitly established that the transfers at issue were a "paper transaction." Therefore, even when the court interprets the evidence in a light most favorable to the Plaintiff, it becomes clear that the agreement at issue was formulated to achieve an purpose in contravention of the law.

"Although it is well established that parties are free to contract for whatever terms on which they may agree ... it is equally well established that contracts that violate public policy are unenforceable.... As a general rule, a court will [not] lend its assistance in any way toward carrying out the terms of a contract, the *inherent purpose* of which is to violate the law ...." (Citation omitted; emphasis in original; internal quotation marks omitted.) *Vaccaro* v. *D'Angelo*, 184 Conn. App. 467, 490, 195 A.3d 443 (2018). Accordingly, "[c]ontracts that are illegal may defy public policy, in which case they are void and unenforceable.... The question of [w]hether a contract is enforceable or illegal is a question ... to be determined from all the facts and circumstances of each case. Similarly ... the question [of] whether a contract is against public policy is [a] question of law dependent on the circumstances of the particular case ...." (Citations omitted; internal quotation marks omitted.) *Carriage House I-Enfield Assn., Inc.* v. *Johnston*, 160 Conn. App. 226, 245-46, 124 A.3d 952 (2015). As it is clear that the intent behind the agreement at issue was to achieve a purpose in contravention of the Medicaid law, it cannot be enforced by this court.

***5** In an attempt to avoid this result, the Plaintiff primarily relies on *Cohen* v. *Cohen*, 182 Conn. 193, 438 A.2d 55 (1980). *Cohen* arose in the following factual and procedural context. The plaintiff, who was going through dissolution proceedings, purchased a condominium as joint tenants with her son, the defendant. Although title was held by both parties, the defendant did not contribute any funds to the purchase of the property. Rather, the plaintiff chose for her son to have joint ownership because she "feared that [her husband] would acquire some interest in the condominium if she died; and the defendant warned her that property held in her name could be reached by his father's creditors and that it was likely that his father would try to use such property to secure or to satisfy his debts." Id., 197. The parties made this agreement "with the understanding that the defendant would deed his interest back to his mother upon her request." Id., 197-98. Despite this apparent agreement, the defendant refused to reconvey the property to the plaintiff. Our Supreme Court determined that, under the facts presented in *Cohen*, the imposition of a constructive trust was appropriate because "[t]he defendant in this case successfully persuaded his mother to place the property involved in the joint estate ostensibly to defeat the potential claims of his father's creditors. Although he promised to reconvey to his mother his record interest in the property at a future date, he never, in fact intended to do so. These facts support a conclusion that the defendant took personal advantage of his confidential relationship with his mother by fraud and artifice." Id., 205. Key to the Supreme Court's conclusion in this regard was "[t]here is no indication here that the Plaintiff intended to perpetrate a fraud upon the court ...." Id.

At first blush, it may appear that *Cohen* is factually similar to the present case. Nevertheless, this matter is more analogous to *Pappas* v. *Pappas*, 164 Conn. 242, 320 A.2d 809 (1973). In *Pappas*, the plaintiff, who was going through divorce proceedings, "consulted with his children ... and formulated a plan to transfer his real estate to them until his marital difficulties were over and then have the property transferred back to him. Prior to the transfer, the defendant[, one of the plaintiff's children,] agreed to reconvey the properties after the plaintiff had settled his problems with his wife." Id., 244. As stated by our Supreme Court: "At a deposition taken in connection with the divorce action, the plaintiff testified that he transferred the real estate to his children in satisfaction of certain financial and other obligations to them." Id. "Nevertheless, as part of his plan for the ultimate retention of this property, the plaintiff misrepresented the transfer as being absolute. The plaintiff persisted in this misrepresentation when, in connection with the divorce action, he testified falsely under oath concerning the consideration given for the transfer. This testimony, given after the initiation of the divorce action, along with the Plaintiff's testimony in this case, constituted a fraud on the court." Id., 245. When the defendant refused to reconvey the subject properties back to the plaintiff, the trial court imposed a constructive trust. The Supreme Court determined this course of action was in error

because the facts indicated that the plaintiff in *Papas* acted with unclean hands and perpetrated a fraud on the court. Id., 247. Accordingly, the case was remanded to the trial court with direction to enter judgment in favor of the defendant.

The evidence indicates that the series of purported transactions here were undertaken with the intent to shield the property from Medicaid and to enroll Carbone in a government program for which she would not otherwise be eligible. As noted by the Vermont Supreme Court: "it is well settled that one who seeks relief in equity must come to the court with clean hands.... [A] party requesting a constructive trust on property transfer[red] ... to avoid his creditors ... would not appear to meet this requirement.... The same principle applies when the object of the conveyance is not to defraud a private creditor but to mislead the government." (Citations omitted; internal quotation marks omitted.) *Shattuck* v. *Peck*, 193 Vt. 123, 128 70 A.3d 922 (2013). "Courts have thus refused to impose a constructive trust in a variety of circumstances where the original transfer was to avoid a governmental penalty or obtain an unwarranted governmental benefit." Id., 129. Similarly, the Alabama Court of Civil Appeals has recognized that this rule applies when a party "alleges that [another] conveyed the property to her in order to defraud a governmental entity into considering her to be eligible for Medicaid and other government benefits." *McMichael* v. *Flynn*, 686 So. 2d 254, 256 (Ala. Ct. Civ. App. 1995), appeal dismissed, 686 So. 2d 257 (Ala. 1996). Simply put, "[h]e who comes into equity must come with clean hands, a court of equity will not lend its aid in any manner to one who has been guilty of unlawful or inequitable conduct in a transaction from which he seeks relief, nor to one who has been a participant in a transaction the purpose of which was to defraud a third person, to defraud creditors, or to defraud the government." (Internal quotation marks omitted.) *Estate of Bruner* v. *Bruner*, 338 F.3d 1172, 1177 (10th Cir. 2003). Accordingly, as the purpose of the agreement to reconvey the property from the Defendant to the Plaintiff and his siblings after Carbone's death was part of a scheme to work around state and federal law, the Plaintiff cannot succeed on either her legal based causes of action (breach of contract/tortious interference) or those that sound in equity (unjust enrichment/ constructive trust.) The court observes that it was only a matter of chance and timing—not reasonably contemplated at the time of the subject oral agreement and other transactions--that Carbone happened to inherit funds from her long-time companion making her again ineligible for Medicaid and able to pay back the lien.

Statute of Frauds

***6** The Defendant further argues that he is entitled to judgment in his favor pursuant to the statute of frauds,[7] specifically, that portion of the statute of frauds that prohibits oral agreements concerning the sale of real property.[8] As the purported agreement between the Defendant and Carbone to reconvey the property upon Carbone's death was not in writing, the Defendant asserts that it cannot be enforced by the courts. In opposition, the Plaintiff contends this portion of the statute of frauds does not govern this matter because it is inapplicable to trusts that arise by operation of law.

General Statutes § 52-550 provides in relevant part: "(a) No civil action may be maintained in the following cases unless the agreement, or a memorandum of the agreement, is made in writing and signed by the party, or the agent of the party, to be charged ... (4) upon any agreement for the sale of real property or any interest in or concerning real property ...." "The provision requires that every agreement or memorandum of an agreement for the sale of real property or any interest in or concerning real property be in writing and signed by the party to be charged in order for a civil action to be maintained against that party.... The primary purpose of the statute of frauds is to provide reliable evidence of the existence and the terms of the contract ...." (Citation omitted; internal quotation marks omitted.) *Sovereign Bank* v. *Licata*, 116 Conn. App. 483, 496, 977 A.2d 228 (2009), appeal dismissed, 303 Conn. 721, 36 A.3d 662 (2012).

In paragraph eighteen of her Complaint, the Plaintiff alleges that "the agreement [at issue] was not reduced to writing." Additionally, according to the evidence introduced at trial, it is undisputed that any contract between Carbone and the Defendant was oral. As the contract in the present case was for the conveyance of real estate, the statute of frauds plainly applies. In opposition, the Plaintiff only cites to law holding that "[i]n this jurisdiction ... the statute of frauds does not apply to trusts arising by operation of law.... Within this category fall constructive trusts ...." (Citation omitted; internal quotation marks omitted.) *Jarvis* v. *Lieder*, Superior Court, Judicial District of Ansonia-Milford, Docket No. CV-06-5001737-S (October 6, 2008, *Levin, J.*), aff'd, 117 Conn. App. 129, 978 A.2d 106 (2009), citing, *Worobey* v. *Sibieth*, 136 Conn. 352, 355-56, 71 A.2d 80 (1949). Although this is a correct statement of the law, the court has already concluded that a constructive trust is inappropriate under the facts of this matter. Accordingly, even if the evidence offered at trial is interpreted in a manner most favorable to the

Plaintiff, she cannot escape the application of the statute of frauds. This observation provides an additional basis to enter judgment in favor of the Defendant. [9]

Conclusion

***7** For the foregoing reasons, the court treats the Defendant's Motion for Directed Verdict/Post-trial Brief as a motion for judgment of dismissal and judgment pursuant to Practice Book § 15-8, and it grants that motion. Judgment shall enter accordingly in favor of the Defendant.

All Citations

Not Reported in Atl. Rptr., 2024 WL 2150288

Footnotes

1 The other named Defendants in this case are Paula Crabb, Thomas Carbone, Karen L. Bowens, Toni A. Clark, Douglas W. Dorsey, and Dime Bank. The first five of these Defendants are named because they may have a legal interest in the property at issue. Dime Bank is listed as a Defendant because it holds an open-ended mortgage on the subject property. None of these Defendants have appeared, and the Plaintiff does not allege that any of these Defendants have committed wrongful acts. Therefore, for the sake of convenience, Benjamin Carbone, Jr. will be referred to as the sole Defendant.

2 According to the Complaint, Jacqueline Carbone Dorsey passed away on January 6, 2021. Douglas W. Dorsey is Jacqueline's surviving spouse, and Toni A. Clark is her only child. Therefore, these individuals are listed as Defendants in this matter instead of Jacqueline Carbone Dorsey.

3 The Defendant disputes this characterization of the agreement at issue.

4 The Complaint alleges this will was executed on February 28, 2020, whereas the date on the document is February 26, 2020. (Pl's Exh. 7.)

5 The Plaintiff offered evidence at trial that Carbone inherited substantial assets after the death of her long-time companion, Joseph Siragusa. According to the Plaintiff, with these additional funds, Carbone became ineligible for Medicaid.

6 42 U.S.C. § 1396p (c) (2) provides in relevant part: “An individual shall not be ineligible for medical assistance ... to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—

(ii) a child of such individual who ... is ... totally disabled ....”

7 This special defense only specifically applies to counts one through three of the Complaint.

8 The Defendant also argues that the Plaintiff's claims are barred by the portion of the statute of frauds that prohibits oral agreements that cannot be performed within one year. “Our case law in Connecticut ... has taken a narrow view of the one-year provision of the statute of frauds now codified as [General Statutes] § 52–550 (a) (5).... [Our Supreme Court has] held that it has been repeatedly adjudged, that unless it appear[s] from the agreement itself, that it is not to be performed within a year, the statute does not apply.... The statute of frauds plainly means an agreement not to be performed within the space of a year, and expressly and specifically so agreed.... It does not extend to cases where the thing only may be performed within the year.” (Citation omitted; emphasis omitted; internal quotation marks omitted.) *C.R. Klewin, Inc.* v. *Flagship Properties, Inc.*, 220 Conn. 569, 577-78, 600 A.2d 772 (1991). As it was certainly possible that Carbone could

have passed away and then the Defendant in turn proceeded to convey the property to the Plaintiff and his siblings within one year, this portion of the statute of frauds does not defeat the Plaintiff's causes of action.

9 Having reached the conclusion that the Defendant is entitled to judgment in his favor with respect to his first two arguments, the court need not examine his last argument, i.e., that the Plaintiff has failed to demonstrate that there was an agreement between Carbone and the Defendant. In any event, within the procedural context that is currently before this court, it would be inappropriate to reach this ground because the court would necessarily have to engage in fact finding. Under our rules of practice, "[o]n ... a [Practice Book § 15–8] motion, the court is confined to determining whether the Plaintiff's evidence, if believed and if given the benefit of all favorable inferences, makes out a prima facie case.... The court, on such a motion, may not make findings of fact, either favorable or unfavorable to the Plaintiff." (Emphasis omitted; internal quotation marks omitted.) *Charter Oak Lending Group, LLC* v. *August*, 127 Conn. App. 428, 436, 14 A.3d 449, cert. denied, 302 Conn. 901, 23 A.3d 1241 (2011).

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689 S.W.3d 274
Supreme Court of Texas.

TEXAS HEALTH AND HUMAN SERVICES COMMISSION, Petitioner,
v.
ESTATE OF Clyde L. BURT, Linda S. Wallace, Executor, and Linda S. Wallace, Respondents

No. 22-0437
|
Argued October 4, 2023
|
OPINION DELIVERED: May 3, 2024

Synopsis

Background: Homeowner, individually and as executor of the estate of her father, sought judicial review of Texas Health and Human Services Commission's decision that her parents were ineligible for Medicaid nursing-facility assistance due to their one-half interest in daughter's home. The 53rd District Court, Travis County, Lora J. Livingston, J., reversed and remanded. Commission appealed. The Austin Court of Appeals, Byrne, C.J., 644 S.W.3d 888, affirmed. Commission petitioned for review, which was granted.

Holdings: The Supreme Court, Bland, J., held that:

under the plain language of statute excluding a Medicaid applicant's home when determining resources for purposes of eligibility for Medicaid benefits, daughter's house was not applicants' home;

federal and state regulations aligned with reading "home" to require that the home currently be the principal place of residence, coupled with an intent to return, before claim for assistance arose;

ownership, occupancy, and intent to return to daughter's house never coincided in the property before claim for Medicaid assistance arose; and

pursuant to Social Security Administration's (SSA) Program Operations Manual System, parents left their house with no intention to return when they sold it to daughter and lived elsewhere for seven years, so that house had ceased to be their principal place of residence long before claim for Medicaid assistance arose.

Reversed and rendered.

Hecht, C.J., filed dissenting opinion in which Boyd and Devine, JJ., joined

Procedural Posture(s): On Appeal; Petition for Discretionary Review; Review of Administrative Decision.

***277** On Petition for Review from the Court of Appeals for the Third District of Texas

Attorneys and Law Firms

Brent Webster, Houston, Kara D. Holsinger, Bill Davis, Elizabeth J. Brown Fore, Austin, Atty. Gen. W. Kenneth Paxton Jr., Shawn Cowles, Judd E. Stone II, Laura Diller, Ryan Baasch, for Petitioner.

Jacob Hale, Waxahachie, for Respondents.

Opinion

Justice Bland delivered the opinion of the Court, in which Justice Lehrmann, Justice Blacklock, Justice Busby, Justice Huddle, and Justice Young joined.

To qualify for Medicaid assistance, an applicant's resources, like cash and assets, must fall below a threshold level. The calculation of resources for this purpose excludes the applicant's home. The issue presented in this case is whether an interest in property purchased with cash after a Medicaid applicant enters a skilled-nursing facility qualifies as a "home" under federal law, excluding it from the calculation that determines Medicaid eligibility.

The Texas Health and Human Services Commission concluded that the property ***278** interest is not excluded, and thus it denied the claim for assistance. The trial court reversed the agency's determination, and the court of appeals affirmed. The court of appeals held that a property interest created after admission to a skilled-nursing facility can be excluded from the resources used to determine Medicaid eligibility if the applicant states an intent to live at the property in the future. In its view, this is so even though the purchase took place after the Medicaid claim arose, using funds that otherwise qualified as resources for calculating Medicaid eligibility. [1]

We hold that a "home" is the applicant's principal place of residence before the claim for Medicaid assistance arises, coupled with the intent to reside there in the future. A property interest purchased with qualifying resources after the applicant moves to a skilled-nursing facility is an available resource for determining Medicaid eligibility under federal eligibility rules, as the property was not the applicant's principal place of residence at the time the claim for benefits arose. We reverse and render judgment in favor of the Commission.

I

Clyde and Dorothy Burt purchased a house in Cleburne, Texas, and lived there many years. In 2010, however, they sold the house to their daughter and son-in-law, Linda and Robby Wallace. The Burts moved to a rental property the Wallaces owned.

About seven years later, in August 2017, the Burts moved to a skilled-nursing facility. At the time, the Burts had cash assets and cash value in a life insurance policy; both count as available resources for Medicaid eligibility.[2] After moving into the facility, the Burts used these assets to buy an undivided one-half interest in the Cleburne house from the Wallaces.[3] The Burts then executed a Lady Bird deed in favor of the Wallaces.[4] By executing the deed, the Burts granted their newly acquired one-half interest back to the Wallaces, reserving an enhanced life estate. As a result, the Burts' undivided one-half interest in the Cleburne house reverted to the Wallaces upon the Burts' deaths. After these transactions, the Burts were left with qualifying resources of $2,016.10, which is under the $3,000 maximum resource threshold for couples to be eligible for Medicaid assistance.[5]

On the day of the sale, Clyde Burt executed a Form H1245, informing the Commission that he considered the Cleburne house to be his home and principal place of ***279** residence, to which he intended to return. Shortly thereafter, he submitted the form along with his and his wife's joint application for Medicaid nursing-facility assistance. While their application was pending, the Burts died, having never left the skilled-nursing facility. They incurred $23,479.35 in costs for their care.

The Commission denied the estate's claim for Medicaid assistance. It determined that the Burts' interest in the Cleburne house was not excludable as a resource for determining Medicaid eligibility. A Commission hearing officer and reviewing attorney upheld the decision. They reasoned that the property interest was not excludable as the Burts' home because the home had not been the Burts' residence in the years before they entered the nursing facility.[6]

Linda Wallace, as executor and beneficiary of her father's estate, petitioned for review in the district court, arguing that the Commission should have excluded the Burts' interest in the Cleburne house from the Burts' available resources.[7] Agreeing, the trial court reversed the Commission's decision.

The court of appeals affirmed, holding that an applicant's principal place of residence and home for Medicaid eligibility purposes turns on the applicant's subjective intent.[8] The court of appeals reasoned that "the purposes of Medicaid are better served by allowing an applicant to claim the home exemption for a home he buys while in a nursing facility," because renters and homeowners "will be in the same need of a home upon ... discharge from the institution."[9]

The Commission petitioned this Court for review, arguing that the court of appeals' expansive interpretation of "home" fails to comport with "home" under state and federal law. We granted review.

II

We review the Commission's denial of Medicaid assistance under the substantial evidence rule.[10] Under that standard, courts first "determine whether the agency's construction contradicts the statute's plain language."[11] Statutory interpretation is a question of law we consider de novo.[12] If the Commission's construction comports with the statute, then a reviewing court should uphold the Commission's decision "if the evidence is such that reasonable minds could have reached the conclusion that the agency must have reached in order to justify its action."[13]

A

Medicaid is a federal and state assistance program that provides medical ***280** and skilled-nursing care for qualifying persons.[14] Federal law sets Medicaid's parameters, and the states enact legislation to implement the program.[15] In Texas, the Health and Human Services Commission administers Medicaid.[16]

Texas's methodology for determining income and resource eligibility must be "no more restrictive[ ] than the methodology ... under the [federal] supplemental security income program."[17] Under that standard, an applicant's resources must not exceed $2,000 for an individual or $3,000 for a couple.[18] "Resources" includes "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."[19] Under the statute, the Commission must exclude an applicant's "home (including the land that appertains thereto)" from the applicant's available resources.[20]

The Commission argues that the Burts' interest does not qualify as their "home" for Medicaid eligibility. Under the federal statute and federal and state regulations, "home" must be understood as an "actual, lived-in residence"; otherwise, an applicant could exclude any interest acquired after the claim for assistance arises based on the applicant's declared intent to make it a future home. Because the Burts neither lived in the Cleburne house when they applied for Medicaid assistance, nor lived in it during the period before their entry into the skilled-nursing facility, the value of their interest, acquired using Medicaid-available resources after their admission to the skilled-nursing facility, is not excluded.

Ms. Wallace responds that federal law permits an applicant to use resources to purchase a property interest and designate it as a future "home," if the applicant states an intent to live there in the future. This construction converts funds that qualify as "resources" at the time of the claim into assets that do not, but Ms. Wallace argues that the definition of "home" as a place of residence of the applicant at the time the claim arose makes Texas's Medicaid program more restrictive than the federal supplemental security income program.

B

We begin by examining the applicable federal law. "In determining the resources of an individual (and his eligible spouse, if any) there shall be excluded ... the home (including the land that appertains thereto)."[21] The federal law does not define "the home." "When a term is left undefined in a statute, 'we will use the plain and ordinary meaning of the term and interpret it within the context of the statute.' "[22] "To determine a statutory term's common, ordinary meaning, we typically ***281** look first to [its] dictionary definitions ...."[23]

"[H]ome" is "one's principal place of residence: domicile,"[24] and "[a] place where one lives; a residence."[25] Accordingly, a home is the principal place in which one lives and resides, not merely a structure in which one possesses a partial ownership stake. At the time the Burts applied for Medicaid, they did not reside in the Cleburne house. Nor was the Cleburne house their principal residence or domicile during the preceding seven years. Under the plain language of the statute, the Cleburne house was not their "home." The Commission's interpretation is consistent with the plain meaning of the federal statute and no more restrictive than the federal supplemental security income program.

In urging the contrary, Ms. Wallace first observes that the statute does not explicitly require occupancy. To reside and live in a place, however, one must occupy it. The statute does not provide an exclusion for real property or homes generally, but "*the* home."[26] The home connotes a singular location commonly understood to be the place one lives.

Ms. Wallace also counters that it is common for one to consider a property to be a "home" despite being unable to immediately move into it, as for example, when signing closing documents for a house or when a service member purchases a house while on duty abroad. Those examples feature two residences, one in which the person resides and another that the person intends to occupy or has occupied during the relevant time frame. Because the statute excludes "*the* home," an applicant must elect a principal residence to the exclusion of all others. Which residence of two qualifying residences may turn on the homeowner's view of which is the principal one, but both are owned before the applicant files a claim for Medicaid assistance. Absent ownership of multiple residences, "the home" is commonly understood to be the place one resides. The Burts' principal and only home was their rental house. It was not their daughter's Cleburne house, in which they purchased an interest using eligible

Medicaid resources after their claim for assistance arose, then immediately deeded that interest back to her save a life estate.

Finally, Ms. Wallace argues that an occupancy requirement denies renters the preservation of a home after nursing care. This, she contends, contravenes Medicaid's purpose of promoting a return to independence.[27] The court of appeals rested its holding on this argument, noting that a renter needs a home upon discharge as much as a homeowner.[28]

The statute, however, returns a Medicaid applicant to the type of residence the applicant occupied before the claim for assistance arose. The federal government appropriates Medicaid funds to enable states "to furnish (1) medical assistance on behalf of ... aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such ... individuals ***282** attain or retain capability for independence or self-care."[29] The resources statute endeavors to calculate the funds available for care based on an applicant's living situation before the claim for assistance arises; it does not permit the applicant to change the nature of that residence (from renting to owning or from a real property interest to a home) by converting assets that otherwise are available to pay for the applicant's care once the need for that care arises.[30]

One way Congress has sought to limit improper asset transfer and ensure recoverability of Medicaid funds[31] is by imposing a "look-back date," which is tied to the date the applicant files for Medicaid, to scrutinize eligibility.[32] As the look-back period illustrates, the period immediately preceding the applicant's claim is the relevant timeframe for determining eligibility.

Congress has sought to preclude artificial impoverishment, repeatedly narrowing Medicaid eligibility to minimize abuse of the program and to conserve government resources for those most in need.[33] "As always, our mandate is to ascertain and give effect to the Legislature's intent as expressed in the statutory language."[34] The home exemption prevents applicants from having to sell their homes to pay for their care; it does not authorize the conversion of available resources to make them unavailable after the claim for assistance arises. The resources calculation instead does the opposite, requiring liquidation of nearly all assets except a home. If an applicant does not own a home before entering care, then the exclusion does not apply.

C

The Social Security Administration and the Commission have promulgated regulations designed to comport with the exclusion of the home from an applicant's resources.[35] When a statute is unambiguous, we apply its plain meaning ***283** and need not turn to an agency's interpretation.[36] The federal and state regulations in this instance, however, align with reading "home" to require residence before the claim for assistance arises.

The Code of Federal Regulations defines a "home" as "any property in which an individual ... has an ownership interest and which *serves as the individual's principal place of residence.*"[37] The federal regulation thus contemplates current, not future, residency. Similarly, the Texas Administrative Code provides that the Commission "follows [the federal regulation] regarding the treatment of a home, except [the Commission] does not count the equity value of a home that *is the principal place of residence* of an applicant ... if the home is in Texas, *and* the applicant or recipient occupies or intends to return to the home."[38] It requires that the home currently be the principal place of residence, coupled with an intent to return.

Residence is "the act or fact of abiding or dwelling in a place for some time."[39] The Burts did not principally abide or dwell in the Cleburne house. Rather, their principal place of residence before their claim for Medicaid assistance arose was a rental house; thereafter, it was a skilled-nursing facility. Because the Burts did not reside in the Cleburne house in the period before their claim for Medicaid assistance arose, it was not their principal place of residence. Their ownership interest was not concurrent with the Cleburne house serving as their principal place of residence, and therefore it is not an excludable "home" under the federal or state regulations.

Demonstrating this concept, the Code of Federal Regulations provides that "[i]f an individual ... 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."[40] Likewise, the Texas Administrative Code provides that one's principal place of residence is excluded if "the applicant ... occupies or

intends to return to the home."[41] In other words, if an applicant moves out of his principal place of residence, he must intend to return to that home for it to remain excludable. A later developed "intent to return" to the Cleburne house does not bring the Burts within the exclusion because it was not their residence in the years preceding their Medicaid claim. In other words, the Burts' ownership, occupancy, and intent to return never coincided in the property before their claim for Medicaid assistance arose.

The regulations recognize exceptions that illustrate the statutory rule. For example, ***284** an individual who moves out of a principal place of residence with no intent to return because the individual is fleeing domestic violence may exclude it until the individual establishes a new principal place of residence.[42] This subsection does not support the notion that the Burts may maintain a home exclusion for a house they sold years earlier.[43]

Still another section of the federal regulations lends support to a construction requiring occupancy. Subsection (e)(1)—entitled "[p]roceeds from the sale of an excluded home"—permits an applicant to exclude the proceeds from the sale of an excluded residence if they are used within three months to purchase another home.[44] If one sells an excluded home and purchases a new home within three months, it is then "similarly excluded."[45] This allows Medicaid applicants to sell their houses, irrespective of their Medicaid application, so long as the proceeds are invested in a home within three months. This regulation preserves an existing exclusion; it does not create a new exclusion based on future occupancy. Rather, the regulation presumes occupancy of a residence before the claim for assistance arises.

Finally, while the regulations count property "that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance" as available resources, they do not conversely exclude available cash converted to purchase a home after the claim arises.[46] Collectively, the regulations align with the law that does not permit post-claim conversion of eligible resources absent a recognized exception.

Ms. Wallace also relies on the Social Security Administration's Program Operations Manual System to support her argument that an applicant's subjective intent is all that matters. The Program Operations Manual is "used by Social Security employees to process claims for Social Security benefits."[47] It defines "[p]rincipal place of residence" as "the dwelling the individual considers their established or ***285** principal home and to which, if absent, they intend to return."[48]

The Manual does not have the force and effect of law; it is the statute that controls.[49] Written employee guidance cannot be used to contravene a statute. Even so, Ms. Wallace misapprehends the Manual. While the Manual uses "considers" in defining *principal* place of residence, it does not negate that one must reside in a house to include it among properties that can qualify as an "established or principal" home. As with absent service members, one may have more than one "dwelling" or residence, but the principal place of residence is the one the individual considers his "established or principal" home.[50] Recognizing as much, the Manual acknowledges that " 'intent to return' ... applies only to the continued exclusion of property which met the definition of the individual's home prior to the time the individual left the property."[51] In other words, the property must be the applicant's principal place of residence before the applicant's departure with an intent to return to it for it to remain excludable. The Manual also provides that "[p]roperty ceases to be the principal place of residence as of the date that the individual left it with no intention of returning."[52] The Burts left the Cleburne house with no intention to return when they sold it to the Wallaces, living elsewhere for seven years. Accordingly, under the Manual, it had ceased to be their principal place of residence long before the claim for Medicaid assistance arose.

D

Residency is a familiar concept in other areas of the law. While not controlling in the interpretation of a federal statute, we note that requiring physical presence, and not merely future intent, coheres with this Court's interpretation of residence in areas such as election law and civil procedure. For example, in *Mills v. Bartlett*, an election law case, we held that "residence cannot be determined by intention alone."[53] While subjective intent plays a role in determining primary residence, "action" is also a factor.[54] Ultimately, "[n]either bodily presence alone nor intention alone will suffice to create the residence, but when the two coincide[,] at that moment the residence is fixed and determined."[55] Similarly, in *Owens Corning v. Carter*, a case regarding a statute that mandated

dismissal of certain asbestos lawsuits brought by non-Texas residents, we held that "although intent is *necessary* ***286** to establish a permanent residence, it alone is not *sufficient* to establish a permanent residence." [56] The same holds true here. Intent is a necessary element of establishing a home, but intention alone is insufficient. It must coincide with presence at some point. The Burts declared their intent to principally reside in the Cleburne house, but their intent failed to coincide with their physical presence.

* * *

We hold that a Medicaid applicant's "home," for purposes of 42 U.S.C. § 1382b, is the applicant's principal place of residence before the claim for assistance arises, coupled with the applicant's intent to return to that residence in the future. The purchase of a property interest with Medicaid-available funds after the claim arises does not exclude that interest from the calculation of available resources. Because the Commission did not err in calculating the Burts' eligibility for Medicaid, we reverse the judgment of the court of appeals and render judgment for the Commission.

Chief Justice Hecht filed a dissenting opinion, in which Justice Boyd and Justice Devine joined.

Chief Justice Hecht, joined by Justice Boyd and Justice Devine, dissenting.

For 36 years, Clyde and Dorothy Burt lived in a home on Green River Trail. They then sold it to their daughter and son-in-law, the Wallaces, and rented another home the Wallaces owned. After seven years there, and a few weeks before their 89th birthdays and 70th wedding anniversary, the Burts moved into a skilled-nursing facility, intending to apply for Medicaid. To be eligible, their resources couldn't exceed $3,000, excluding their home. [1]

So, the Burts repurchased a half interest in their long-time Green River Trail home for fair market value. This purchase reduced their worldly possessions from not quite $65,000 cash to just over $2,000. They completed an HHSC form that same day, stating that they considered Green River Trail to be their "home and principal place of residence", that their absence was "temporary", and that they intended to "return to live in [their] home in the future, if possible." It was not to be. Within three months, Clyde passed from this life, and Dorothy followed two months behind him.

The Burts' Medicaid application would've covered a few weeks' health costs—a little less than $24,000. But HHSC denied the Burts' Medicaid application, concluding that Green River Trail couldn't have been their home because they never lived there after buying the half interest from the Wallaces. The trial court reversed, and the court of appeals affirmed the trial court. [2] The Court reverses both lower courts based on its reading of the word "home". But its reading, unlike those of the courts below, conflicts with controlling regulations and the design of the Social Security Act. In the Court's view, the Burts' avowed intent of returning to Green River Trail to live out the last of their days wasn't wise planning and romantic aspiration, but deceptive, "artificial impoverishment" to abuse Medicaid and "saddle future generations with obligations to the few who undertake elaborate estate planning to impoverish their elderly parents," ***287** [3] all of which is very unfairly said of the Burts. [4] I respectfully dissent.

I

The federal statute governing Medicaid eligibility provides that in determining an applicant's resources, the "home" is excluded [5] but doesn't define the word. The Court looks to dictionary definitions as it often does when statutory terms are undefined. But Texas law provides that in determining Medicaid eligibility, HHSC "follows" 20 C.F.R. § 416.1212 "regarding the treatment of the home". [6] That regulation does define "home". Looking to dictionary definitions is thus foreclosed.

Specifically, Section 416.1212(a) defines a "home" as: "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." [7] The Court argues that "[t]o reside and live in a place, ... one must occupy it." [8] But Section 416.1212(c) provides that "[i]f 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." [9] The reasonable implication is that if an individual moves out *with the intent to return*, the home remains his principal residence.

That reading of subsection (c) is borne out by subsection (d), which provides that if a beneficiary flees a home due to

domestic abuse, the home nevertheless remains the person's principal place of residence, even without an intent to return, until a "new" principal place of residence is established. In effect, an intent to return to the home is presumed, however unlikely, until affirmatively rejected, and the home isn't a countable resource even though the domestic abuse victim has moved out. [10]

The Court argues that the Burts couldn't have intended to *return* to Green River Trail after buying an interest from the Wallaces because they didn't reside there in the "years preceding" their Medicaid claim. [11] But the Burts had occupied their Green River Trail home before applying for Medicaid—for 36 years. That they'd lived in a rental home for seven years in the interim doesn't detract from the fact that in acquiring a half interest in the home and entering nursing care, they were hoping to return to their long-time home. It was their very real and poetic goal, as they expressly affirmed. As the Court acknowledges, if the Burts had sold to the Wallaces and rented from them for ***288** even one day before repurchasing their half interest in the home, the Court wouldn't dispute that they were intending to "return" to the home they had long occupied. If anything, being removed from their long-time home for seven years only inspired the Burts to return.

According to the Court, HHSC is concerned that "an applicant [may] exclude any interest acquired after the claim for [Medicaid] assistance arises based on the applicant's declared intent to make it a future home." [12] Whatever the merits of that concern, this isn't that case.

The court of appeals argued that an applicant's subjective view of a place as home should control, pointing to the Social Security Administration Program Operations Manual System's definition of "principal place of residence" as "the dwelling the individual *considers* [his or her] established or principal home and to which, if absent, [he or she] intend[s] to return." [13] The Manual provides, as the Court notes, that the "intent to return" requirement "applies only to the continued exclusion of property which met the definition of the individual's home prior to the time the individual left the property." [14] From this the Court asserts that considering a house a home doesn't negate an occupancy requirement. [15] But the Manual states that a "right to use for life" is evidence of ownership [16] and that when an individual owns only "one residence", HHSC should "assume that the alleged home is the individual's principal place of residence." [17]

Importantly, the Manual instructs that an applicant's "statement" regarding their intent to return is dispositive unless it is "self-contradictory", [18] a term the Manual defines clearly and narrowly. [19] The Burts' statement of intent to return to Green River Trail was clear, unambiguous, and internally consistent. Under the Manual, the Burts' intent to return to their long-term home should not be an issue. The Court's occupancy requirement thus conflicts with the Manual. The Court discounts the Manual as not having the force and effect of law without acknowledging that given its use in administering the Medicaid program, it should certainly, at the very least, be considered informative. [20]

***289** All of this should be for another day. Very literally, when the Burts applied for Medicaid, they owned a home they'd occupied before entering a nursing facility, they considered it to be their established or principal home, and they intended to return to it.

II

The injustice the Burts suffer today is only compounded by the Court's and HHSC's position: that if only the Burts had bought the half interest in their home from the Wallaces and lived there for a day on their way to the nursing facility —if only they'd acted in reverse order—the value of their interest would've been excluded from their assets as a home in determining their Medicaid eligibility. So as long as elderly Medicaid applicants have read today's opinion, they can avoid falling into the trap that ensnared the Burts. At least some can, as the court of appeals noted:

> Under [HHSC]'s argument, an applicant can exempt his home if he lives there for one day before entering a nursing facility, but an applicant living in an apartment and in the process of buying a home who, the day before closing, suffers a fall requiring nursing care cannot. [21]

But even if that catastrophe is unlikely, and the Court's decision were mostly fixable, the court of appeals' concern lingers:

> Such a distinction is not supported by the language found in the various federal statutes and rules, makes no practical sense, and in no way advances the purposes behind the assistance programs in question. [22]

The Court's textually untethered decision carries a high risk of interfering with the especially "intricate" [23] and delicate legal machinery of Medicaid, SSI, and other federal programs. For instance, 20 C.F.R. § 416.1212(d) provides that a beneficiary who flees her principal place of residence because of domestic abuse doesn't lose her benefits, as the prior residence—occupied by her abuser—remains excludable and is still "consider[ed] to be the individual's principal place of residence". [24] That residence remains excludable "until such time as [she] establishes a new principal place ***290** of residence". [25] Under the Court's view, however, a beneficiary who was a victim of domestic abuse couldn't establish a "new principal place of residence" by buying a new home because she never would've *occupied* it before applying for benefits. Thus, she couldn't intend to "return" there. The Court dismisses the inconsistency as an exception to the occupancy requirement. [26] But given that such a requirement is nowhere mentioned in the regulation, the specific treatment of a domestic-violence victim's home is better read as confirmation that no general occupancy requirement exists than as an exception to one never actually mentioned.

The Court's judicially created prior-occupancy requirement would also interfere with other federal programs. In 2014, Congress enacted the Achieving a Better Life Experience ("ABLE") Act. [27] This Act authorizes the creation of tax-advantaged savings accounts to shelter funds, subject to a funding ceiling. [28] Importantly, any qualifying disbursements from ABLE accounts are prohibited from affecting a person's eligibility for government assistance.

Before ABLE accounts became widely available, "saving money proved challenging for many people living with a disability because [government] programs often have income and resource limits." [29] But today, disabled beneficiaries can save and invest substantial sums and may also withdraw funds without penalties [30] for Qualified Disability Expenses, a category that includes "[h]ousing" expenses. [31] Several states, including Texas, [32] have implemented ABLE programs. And many disabled beneficiaries on SSI and Medicaid have since relied on the QDE exemption to buy their first homes. [33]

It stands to reason that a new home purchased with ABLE funds must itself be excludable, even though a beneficiary hasn't previously occupied it. Indeed, that very fact is a feature —not a bug—in the program. The ABLE Act was meant to provide opportunities for financial security and independence previously inaccessible to disabled beneficiaries.

The Court's prior-occupancy requirement would force disabled beneficiaries (except those fortunate few who've already got homes before applying for assistance) into a Hobson's choice: you may have housing independence, but only if you're ***291** willing to give up your federal aid. Stated differently, once you're on government assistance, "you'll own nothing, and you'll be happy."

This entirely avoidable outcome frustrates one of the Act's central goals of "improving [the] health, independence, or quality of life [of] designated beneficiar[ies]." [34] It ignores the realities of how this system (as designed) is actually working. Disabled beneficiaries are becoming first-time homeowners without losing their benefits. [35] More importantly—in disregard of the Act's text, which states that "[h]ousing" counts as a qualified disability expense —the Court renders hollow the promise that QDEs won't affect a beneficiary's "eligibility for government assistance programs." [36]

The Court offers that its holding "does not interfere" with an ABLE account holder's "ability to purchase a new home". [37] But disabled beneficiaries with ABLE accounts and elderly applicants like the Burts can't be subject to disparate eligibility criteria under federal law, which requires eligibility standards in state-run programs to be "comparable for all groups". [38] The Court's holding leaves the concern that when an ABLE account holder in Texas purchases a "new" house without having previously resided there, the new

house won't qualify as an excludable "home" for Medicaid eligibility purposes.

III

Finally, as the court of appeals noted, an occupancy requirement disadvantages renters by denying them, in the Court's words, "the preservation of a home after nursing care [in contravention of] Medicaid's purpose of promoting a return to independence."[39] Here is the Court's response:

> The [federal Medicaid] statute ... returns a Medicaid applicant to the type of residence the applicant occupied before the claim for assistance arose.... The resources statute endeavors to calculate the funds available for care based on an applicant's living situation before the claim for assistance arises; it does not permit the applicant to change the nature of that residence (from renting to owning or from a real property interest to a home) by converting assets that ***292** otherwise are available to pay for the applicant's care.

As support, the Court points to the use of a "look-back date ... to scrutinize eligibility" but fails to note that under the relevant statute, an applicant is only rendered ineligible for Medicaid by transferring property "for *less than fair market value*".[40] A look-back date is irrelevant when, as in this case, it is undisputed that the Burts reacquired an interest in their home for fair market value. The Court cites nothing in federal law that would disqualify a Medicaid applicant who has been living in rented space, faces the need for covered medical care, and buys a home to provide for future restoration to healthy and independent life, even if, in so doing, he reduces his resources for eligibility.

To the contrary, as we have explained, federal law incentivizes Medicaid applicants to provide wisely for their future. Federal law cannot be reasonably construed to limit Medicaid applicants' efforts to care for themselves if they happened to be renters before they applied for benefits. It may be, as the Court observes, that "Congress has sought to preclude artificial impoverishment, repeatedly narrowing Medicaid eligibility to minimize abuse of the program and to conserve government resources for those most in need."[41] There is nothing to indicate, however, that Congress perversely provided that the more disadvantaged one is in applying for Medicaid, the less benefit it provides—much less that the benefits structure intentionally discriminates against renters.

* * * * *

"Home," Robert Frost wrote, "is the place where, when you have to go there, They have to take you in."[42] Green River Trail was home to the Burts when they applied for Medicaid. I would affirm the court of appeals. I respectfully dissent.

All Citations

689 S.W.3d 274, Med & Med GD (CCH) P 308,077, 67 Tex. Sup. Ct. J. 622

Footnotes

1 644 S.W.3d 888, 895 (Tex. App.—Austin 2022).

2 *See* 20 C.F.R. § 416.1201. The Burts also had railroad retirement income.

3 The Burts represented in their Medicaid application that they transferred cash and their interest in a life insurance policy to their daughter to purchase their property interest in the Cleburne house for $54,379.18. The parties agree that the Burts' ownership interest had a market value of $82,048.50, but the Commission does not challenge the purchase as a transfer for less than fair market value. *See id.* § 416.1246(a), (e)

(providing that "[t]ransfer of a resource for less than fair market value is presumed to have been made for the purpose of establishing ... Medicaid eligibility" and may be included in an applicant's resources calculation).

4 A "Lady Bird deed," also known as an "enhanced-life-estate deed," is "[a] deed that allows a property owner to transfer ownership of the property to another while retaining the right to hold and occupy the property and use it as if the transferor were still the sole owner." *Lady Bird deed*, Black's Law Dictionary (11th ed. 2019).

5 *See* 42 U.S.C. § 1382(a)(3)(A).

6 *See* 1 Tex. Admin. Code § 358.348; Tex. Health & Hum. Servs. Comm'n, Medicaid for the Elderly and People with Disabilities Handbook F-3000, Home (2021).

7 *See* Tex. Gov't Code § 531.019. Dorothy Burt is not named as a party. Neither party contends that this affects the disposition of this case.

8 644 S.W.3d at 890, 893.

9 *Id.* at 894 (citing *Est. of Seffer v. Tex. Health & Hum. Servs. Comm'n*, No. D-1-GN-08-000790 (419th Dist. Ct., Travis County, Tex. Dec. 16, 2008)).

10 *See R.R. Comm'n of Tex. v. Cont'l Bus Sys., Inc.*, 616 S.W.2d 179, 181 (Tex. 1981); Tex. Gov't Code § 531.019(g).

11 *Sirius XM Radio, Inc. v. Hegar*, 643 S.W.3d 402, 407 (Tex. 2022).

12 *Aleman v. Tex. Med. Bd.*, 573 S.W.3d 796, 802 (Tex. 2019).

13 *Tex. Health Facilities Comm'n v. Charter Med.–Dall., Inc.*, 665 S.W.2d 446, 453 (Tex. 1984) (citing *Suburban Util. Corp. v. Pub. Util. Comm'n*, 652 S.W.2d 358, 364 (Tex. 1983)).

14 *El Paso Hosp. Dist. v. Tex. Health & Hum. Servs. Comm'n*, 247 S.W.3d 709, 711 (Tex. 2008); *see also* 42 U.S.C. §§ 1396–1396w-8.

15 *See El Paso Hosp. Dist.*, 247 S.W.3d at 711; 42 U.S.C. § 1396a; 42 C.F.R. § 430.0.

16 *El Paso Hosp. Dist.*, 247 S.W.3d at 712; Tex. Gov't Code § 531.021.

17 42 U.S.C. § 1396a(r)(2).

18 *Id.* § 1382(a)(3).

19 20 C.F.R. § 416.1201(a).

20 42 U.S.C. § 1382b(a)(1); *see also* 20 C.F.R. § 416.1212(b); 1 Tex. Admin. Code § 358.348(a).

21 42 U.S.C. § 1382b(a).

22 *Hogan v. Zoanni*, 627 S.W.3d 163, 169 (Tex. 2021) (quoting *EBS Sols., Inc. v. Hegar*, 601 S.W.3d 744, 758 (Tex. 2020)).

23 *Tex. State Bd. of Exam'rs of Marriage & Fam. Therapists v. Tex. Med. Ass'n*, 511 S.W.3d 28, 35 (Tex. 2017) (citing *Epps v. Fowler*, 351 S.W.3d 862, 866 (Tex. 2011)).

24 *Home*, Webster's Third New International Dictionary 1082 (2002).

25 *Home*, The American Heritage Dictionary of the English Language 840 (5th ed. 2022).

26 42 U.S.C. § 1382b(a)(1) (emphasis added).

27 *See id.* § 1396-1.

28 644 S.W.3d at 894.

29 42 U.S.C. § 1396-1.

30 This is not the only Medicaid statute that requires residency. For Medicaid applicants residing in an institution, the purchase of a life estate in another's property is considered an improper transfer of assets unless the applicant "resides" at the life-estate property for at least one year after the date of the purchase. *Id.* § 1396p(c)(1)(A), (J).

31 Federal law requires states to recover the costs of long-term care paid through Medicaid for certain categories of applicants from the applicant's estate. *See id.* § 1396p(b); 1 Tex. Admin. Code § 373.101.

32 *See* 42 U.S.C. § 1396p(c)(1)(A), (B). The look-back period is 36 months or 60 months, depending on the circumstances. *Id.* § 1396p(c)(1)(B)

33 Medicaid is for those "whose income and resources are insufficient to meet the costs of necessary medical services" and for "rehabilitation and other services to help such ... individuals." *Id.* § 1396-1; *see also Lewis v. Alexander*, 685 F.3d 325, 333 (3d Cir. 2012) ("Individuals have gained access to taxpayer-funded healthcare while retaining the benefit of their wealth and the ability to pass that wealth to their heirs. Congress understandably viewed this as an abuse and began addressing the problem with statutory standards enacted in 1986."); *Ark. Dep't of Health & Hum. Servs. v. Ahlborn*, 547 U.S. 268, 291, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006) ("Congress, in crafting the Medicaid legislation, intended that Medicaid be a 'payer of last resort.' " (quoting S. Rep. No. 99-146, at 313 (1985))).

34 *Paxton v. City of Dallas*, 509 S.W.3d 247, 256 (Tex. 2017) (citing *TIC Energy & Chem., Inc. v. Martin*, 498 S.W.3d 68, 74 (Tex. 2016)).

35 The Commission is authorized to adopt rules regarding Medicaid's operation in Texas. *See* Tex. Hum. Res. Code § 32.021(c). Pursuant to that power, the Commission has promulgated regulations regarding the calculation of resources that follow federal statutory and regulatory standards. *See, e.g.*, 1 Tex. Admin. Code § 358.321(a), (b).

36 *See Combs v. Roark Amusement & Vending, L.P.*, 422 S.W.3d 632, 635 (Tex. 2013) ("We give [unambiguous] statutes their plain meaning without resort to rules of construction or extrinsic aids. On the other hand, 'if a statute is vague or ambiguous, we defer to the agency's interpretation unless it is plainly erroneous or inconsistent with the language of the statute.' " (quoting *Tex. Dep't of Ins. v. Am. Nat'l Ins. Co.*, 410 S.W.3d 843, 853 (Tex. 2012))); *see also R.R. Comm'n of Tex. v. Tex. Citizens for a Safe Future & Clean Water*, 336 S.W.3d 619, 634 (Tex. 2011) (Jefferson, C.J., concurring) ("We do not defer to agency interpretations of unambiguous statutes.").

37 20 C.F.R. § 416.1212(a) (emphasis added).

38 1 Tex. Admin. Code § 358.348(a) (emphases added).

39 *Residence*, Webster's Third New International Dictionary 1931 (2002); *see also Residence*, Black's Law Dictionary (11th ed. 2019) ("The act or fact of living in a given place for some time.").

40 20 C.F.R. § 416.1212(c) (emphasis added).

41 1 Tex. Admin. Code § 358.348(a)(1) (emphasis added).

42 20 C.F.R. § 416.1212(d).

43 This is not a case about leaving a Medicaid applicant without a home. Presumably the Burts' daughter did not require her parents to transfer nearly all their worldly possessions to her (including a life insurance policy naming her as the beneficiary) to have a home, or to return to the property they occupied during the years before their claim arose. This instead is a case of generational wealth transfer without payment of medical debt—debt that ordinary citizens owe against the estate's assets before they inherit. The law limits government assistance to the truly needy and imposes strict limits on eligibility. The dissent would saddle future generations with obligations to the few who undertake elaborate estate planning to impoverish their elderly parents, at least on paper, after the need for skilled-nursing care arises.

44 *Id.* § 416.1212(e)(1).

45 *Id.*

46 *Id.* § 416.1201. Our holding does not interfere with Texas's ABLE account program or ABLE account holders' ability to purchase a home. ABLE accounts are accounts for qualifying disabled individuals. *Overview*, Texasable, https://www.texasable.org/about/#overview (last visited Apr. 29, 2024). Contrary to the dissent's discussion, a distribution from an ABLE account for Qualified Disability Expenses, including housing, is not included as an asset for eligibility purposes for programs like Medicaid. *See Frequently Asked Questions*, Texasable, https://www.texasable.org/faqs/ (last visited Apr. 29, 2024). If an individual with an ABLE account purchases and moves into a home using those funds, it is an excludable principal place of residence.

47 *POMS Home*, Social Security Administration, https://secure.ssa.gov/apps10/poms.nsf/Home?readform (last visited Apr. 29, 2024).

48 Social Security Administration, Program Operations Manual System SI 01130.100.A.2 (2023), https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130100.

49 *Combs*, 422 S.W.3d at 635 (noting that this Court does not defer to an agency interpretation that is "plainly erroneous or inconsistent with the language of the statute").

50 In the section entitled "How to develop the principal place of residence," the Manual provides that "[a]bsent ownership in more than one residence *or evidence that raises a question about the matter*, assume that the alleged home is the individual's principal place of residence." Social Security Administration, Program Operations Manual System SI 01130.100.C.5.a (2023), https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130100 (emphasis added). Here, the Burts did not reside in the Cleburne house, which raises a question about whether it was, in fact, their principal place of residence.

51 *Id.* at SI 01130.100.C.7.c. (emphasis omitted).

52 *Id.* at SI 01130.100.B.5.

53 377 S.W.2d 636, 637 (Tex. 1964).

54 *Id.*

55 *Id.*

56 997 S.W.2d 560, 571 (Tex. 1999) (citing *Mills*, 377 S.W.2d at 637).

1 42 U.S.C. § 1382(a)(2)(B), (a)(3)(A).

2 644 S.W.3d 888, 890 (Tex. App.—Austin 2022).

3 *Ante* at 282, 284 n.43.

4 A word of caution: *De mortuis nihil nisi bonum.* Diogenes Laertius, *The Lives and Opinions of Eminent Philosophers* 33 (4th cent. A.D.) (quoting Chilon of Sparta, 6th cent. B.C.) (London: G. Bell & Sons, Ltd. 1915). The Burts need not have been ill-motivated to have been wrong on Medicaid law. Actually, they were neither.

5 47 U.S.C. § 1382b(a)(1).

6 1 TEX. ADMIN. CODE § 358.348.

7 20 C.F.R. § 416.1212(a).

8 *Ante* at 281.

9 20 C.F.R. § 416.1212(c) (emphasis added).

10 *Id.* § 416.1212(d) ("If an individual moves out of his or her home without the intent to return, but is fleeing the home as a victim of domestic abuse, we will not count the home as a resource in determining the individual's eligibility to receive, or continue to receive, SSI payments. In that situation, we will consider the home to be the individual's principal place of residence until such time as the individual establishes a new principal place of residence or otherwise takes action rendering the home no longer excludable.").

11 *Ante* at 283.

12 *Ante* at 280.

13 Social Security Administration, *Program Operations Manual System* SI 01130.100.A.2 (Dec. 28, 2023) (available at https://bit.ly.496h268) (emphasis added).

14 *Ante* at 285.

15 *Id.*

16 *Program Operations Manual System*, at SI 01130.100.C.4.

17 *Id.* at SI 01130.100.C.5.a. As the Court notes, the Manual provides that the assumption that an alleged home is the individual's principal place of residence may be overcome only when there is "ownership in more than one residence or evidence that raises a question about the matter." *Ante* at 285 n.50. The Court risks much in reading and applying that provision. First, it ignores that the most natural reading of "evidence that raises a question about the matter", is "evidence that raises a question about *ownership*". And HHSC doesn't challenge the validity of the Burts' ownership interest, their life estate, here. Second, having assumed that its reading is correct, the Court points only to its own novel judicial creation—its prior-occupancy requirement—as "evidence that raises a question". *Id.* Finally, after having begged the question, the Court also fails to point to anything in the Manual, administrative guidance, or caselaw that supports its interpretation.

18 *Id.* at SI 01130.100.E.1.

19 *Id.* at SI 01130.100.E.2.

20 And perhaps more than just informative. The U.S. Supreme Court has upheld Congress's explicit delegation of "broad authority" to the Secretary of the U.S. Department of Health and Human Services "to promulgate regulations defining eligibility requirements for Medicaid." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43, 101 S.Ct. 2633, 69 L.Ed.2d 460 (1981). Thus, the Secretary's definition of "available" resources is entitled "to more than mere weight or deference"—it's entitled to "legislative effect". *Id.* at 44, 101 S.Ct. 2633. Section 1396a, which governs state-run Medicaid plans is littered with cross-references to the SSI program, and in particular, its resource-counting methodology. *See* 42 U.S.C. § 1396a(a)(10)(C)(i), (a)(10)(G), (a)(17), (m)(1). For instance, state plans must "comply with the provisions of [§] 1396p", which regulates "transfers of assets", *id.* § 1396a(a)(18), and incorporates SSI's definition of "resources" from Section 1382b, *id.* § 1396p(c)(5) (citing *id.* § 1382b). Section 1382b itself provides that the Commissioner of the Social Security Administration "shall prescribe" the "time [and] manner in which, various kinds of property must be disposed of in order not to be included in determining an individual's eligibility for benefits." *Id.* § 1382b(b). Finally, as mentioned previously, the Texas Commission expressly claims to follow the Social Security Administration's regulatory definition of "home". 1 TEX. ADMIN. CODE § 358.348(a).

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21 644 S.W.3d at 895.

22 *Id.*

23 *Gray Panthers*, 453 U.S. at 43, 101 S.Ct. 2633 ("The Social Security Act is among the most intricate ever drafted by Congress. Its Byzantine construction ... makes the Act almost unintelligible to the uninitiated.") (internal quotation marks omitted).

24 20 C.F.R. § 416.1212(d).

25 *Id.*

26 *Ante* at 283-84.

27 *Spotlight on ABLE Accounts*, U.S. SOC. SEC. ADMIN. (last accessed Apr. 29, 2024), http://tinyurl.com/2mv8aa8m.

28 *ABLE accounts can help people with disabilities pay for disability-related expenses*, INTERNAL REVENUE SERV. (July 25, 2022), http://tinyurl.com/336pwspu.

29 *ABLE Act: What You Need to Know*, SOC. SEC. MATTERS (Dec. 17, 2020), http://tinyurl.com/3ah36rvp.

30 Specifically, without tax consequences and without losing eligibility for government assistance programs like Medicaid.

31 26 CFR § 1.529A-2(h); SSA, *Spotlight on ABLE Accounts.*

32 *Home*, TEXAS|ABLE (last accessed Apr. 29, 2024), https://www.texasable.org/.

33 Molly Grace, *How people with disabilities can use an ABLE account to buy a house*, BUSINESS INSIDER (Dec. 4, 2023, 4:39 PM), http://tinyurl.com/ykr8xn8j; Robin Rothstein & Chris Jennings, *How to Buy a Home if You Have Disabilities*, FORBES (Aug. 1, 2023), http://tinyurl.com/vwuweduv; *Home*, IL|ABLE (last accessed Apr. 29, 2024), https://illinoisable.com/; *FAQ About ABLE Accounts*, CAL. DEP'T SOC. SERVS. (last accessed Apr. 29, 2024), http://tinyurl.com/yckactmc (explaining that QDEs may be used for the "[p]urchase of a primary residence"); *see also infra* note 35.

34 26 CFR § 1.529A-2(h).

35 *See, e.g., Home*, IL|ABLE (last accessed Apr. 29, 2024), ("Having an IL ABLE Account made it possible for me to save to *buy my first home*." (emphasis added)), ("*Now* our daughter can save for a wide range of things such as ... purchasing an apartment" (emphasis added)).

36 *ABLE accounts*, IRS; *see also FAQs*, TEXAS|ABLE (last accessed Apr. 29, 2024), https://www.texasable.org/faqs/ ("Any funds you withdraw that [are] used to pay for a Qualified Disability Expense ... will [not] be considered an asset for purposes of determining your eligibility for ... Medicaid, SSI and SSDI. Any withdrawal for housing expenses that is ... spent in the month the withdrawal is received will also [not] be considered an asset for SSI purposes.").

37 *Ante* at 284 n.46.

38 42 U.S.C. § 1396(a)(17). *See Mississippi v. Sullivan*, 951 F.2d 80, 83-84 (5th Cir. 1992) ("The structure of the Act supports [the] view that subsection (a)(17) was meant to ensure comparability *between* groups"; a state "would violate subsection (a)(17) if it had one eligibility rule for the [disabled] group and another for the aged group") (emphasis in original).

39 *Ante* at 281 (citing 42 U.S.C. § 1396-1 (stating that the purpose of Medicaid is "to furnish ... rehabilitation and other services to help [disabled and disadvantaged families and] individuals attain or retain capability for independence or self-care")).

40 42 U.S.C. § 1396p(c)(1)(A) (emphasis added).

41 *Ante* at 282.

42 Robert Frost, *The Death of the Hired Man.*

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2024 WL 1712748
Only the Westlaw citation is currently available.

Court of Appeals of Minnesota.

Brad HAMMERBERG, AS TRUSTEE FOR the LEONARD J. AND MARGARET T. SCHUBERT IRREVOCABLE TRUST, DATED JUNE 23, 2005, Respondent,
v.
MINNESOTA DEPARTMENT OF HUMAN SERVICES, et al., Appellants.

A23-0901
|
Filed April 22, 2024

Mille Lacs County District Court, File No. 48-CV-22-1916

Attorneys and Law Firms

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Considered and decided by Reyes, Presiding Judge; Larson, Judge; and Ede, Judge.

NONPRECEDENTIAL OPINION

LARSON, Judge

***1** Appellant Minnesota Department of Human Services (DHS) challenges a district court order reversing a DHS decision that real property held in a trust was subject to a lien under Minn. Stat. § 265B.15 (2022) for the amount of medical assistance (MA) provided to decedent Margaret Schubert during her lifetime. Because the agency correctly determined the real property was subject to a lien, we reverse the district court.

FACTS

The parties stipulated to the following facts. Leonard and Margaret Schubert [1] owned real property in Mille Lacs County. In 2005, the Schuberts created an irrevocable trust, naming respondent Brad Hammerberg as trustee. As relevant here, the Schuberts conveyed real property valued at approximately $480,228 to the trust. The trust instrument provided, in relevant part, that "[t]he settlors or the survivor of them shall be entitled to the use and possession of any real estate held in the trust." The trust instrument also stated:

> On the death of the survivor of the settlors, the trustee shall distribute all property then belonging to the income or principal of the trust to such person or persons out of a class composed of [the settlors'] descendants ... and in such estates, interests and proportions, as the surviving settlor may, by a will specifically referring to this Article, appoint.

Thus, upon the death of the Schuberts, the trust instrument required distribution of the remaining assets to the Schuberts' descendants *per stirpes*, subject to the Schuberts' ability to modify the distribution of the assets in their will. The trust instrument required the trustee to pay all income derived from the trust to the Schuberts. The Schuberts also had the right to remove and replace the trustee. The trustee had the authority to distribute some or all of the principal from the trust to the Schuberts' living children during the Schuberts' lifetime.

Leonard died in 2017 without receiving MA. Margaret applied for MA in 2016. Margaret was determined to be eligible, but the real property held in the trust was not considered an asset. On March 28, 2019, Margaret died after receiving $210,396.93 in MA.

In March 2018 and October 2019, DHS recorded notices of potential claims (hereinafter, the liens) against the real property held in the trust to recover MA paid on behalf of Margaret. In December 2019, Hammerberg requested that DHS withdraw the liens because, in part and primarily, Margaret did not own the real property at the time of her death. DHS declined.

On May 2, 2022, Hammerberg requested a DHS fair hearing. On June 30, 2022, a human-services judge (HSJ) held a dispositive-motion hearing pursuant to Minn. Stat. § 256B.15, subd. 1f(c). Following the hearing, the HSJ recommended that the DHS commissioner affirm DHS's determination that the property was subject to the liens and MA recovery. The HSJ specifically recommended that the appeal was untimely and, even if it was timely, DHS could recover the value of its claims. *See* Minn. Stat. § 256B.15, subd. 1a(b)(5). The commissioner, through her designee the co-chief HSJ, adopted the recommendation.

***2** On September 23, 2022, Hammerberg appealed the commissioner's decision to the district court pursuant to Minn. Stat. § 256.045, subd. 7 (2022). Following a hearing, the district court reversed the commissioner's decision.

DHS appeals.

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DECISION

DHS challenges the district court's decision to reverse the commissioner's determination that the real property held in the trust was properly subject to MA recovery under section 256B.15. After a district court's review, where it accepts no new evidence, we independently review an agency decision without deferring to the district court. *In re Gillette Children's Specialty Healthcare*, 883 N.W.2d 778, 784-85 (Minn. 2016). We show "substantial judicial deference to the fact-finding processes of the administrative agency." *Quinn Distrib. Co. v. Quast Transfer, Inc.*, 181 N.W.2d 696, 699-700 (Minn. 1970).

We review appeals pursuant to section 256.045 using the standard set forth in the Minnesota Administrative Procedure Act, Minn. Stat. §§ 14.001-.69 (2022). *Zahler v. Minn. Dep't of Hum. Servs.*, 624 N.W.2d 297, 301 (Minn. App. 2001), *rev. denied* (Minn. June 19, 2001). We may reverse or modify the commissioner's decision

> if the substantial rights of the petitioners may have been prejudiced because the administrative finding, inferences, conclusion, or decisions are:
>
> (a) in violation of constitutional provisions; or
>
> (b) in excess of the statutory authority or jurisdiction of the agency; or
>
> (c) made upon unlawful procedure; or
>
> (d) affected by other error of law; or
>
> (e) unsupported by substantial evidence in view of the entire record as submitted; or
>
> (f) arbitrary or capricious.

Minn. Stat. § 14.69. We review legal questions de novo. *In re Estate of Barg*, 752 N.W.2d 52, 63 (Minn. 2008).

With these standards in mind, we begin by briefly outlining the law regarding MA benefits and notices of potential claims. We then address whether DHS appropriately recorded the liens on the real property held in the trust. Finally, we address the appropriate disposition in this case.

I.

Medicaid is a cooperative federal-state program that provides medical assistance for certain persons "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1 (2018); *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985); *In re Schmalz*, 945 N.W.2d 46, 50 (Minn. 2020). The federal Medicaid program grants "financial assistance to [s]tates that choose to reimburse certain costs of medical treatment for needy persons." *Schweiker v. Gray Panthers*, 453 U.S. 34, 36 (1981) (quotation omitted); *see also Martin ex rel. Hoff v. City of Rochester*, 642 N.W.2d 1, 9 (Minn. 2002) (stating that Medicaid "is a publicly funded program to ensure medical care to certain individuals who lack the resources to cover the costs of essential medical services").

A state's participation in Medicaid is voluntary. *Choate*, 469 U.S. at 289 n.1; *Schmalz*, 945 N.W.2d at 50. Each participating state enacts and "administers its own program." *Barg*, 752 N.W.2d at 58-59. Minnesota participates in Medicaid through its medical assistance (as previously

indicated, MA) program established under Minn. Stat. §§ 256B.01-.851 (2022). To receive federal Medicaid funds, Minnesota must, in relevant part, "comply with the provisions of [42 U.S.C. § 1396p] with respect to liens, adjustments and recoveries of medical assistance correctly paid, ... transfers of assets, and treatment of certain trusts." 42 U.S.C. § 1396a(a)(18) (2018) (footnote omitted). DHS is responsible for administering the MA program. *See* Minn. Stat. § 256.01, subd. 2(a) (2022) (stating that the DHS commissioner shall "[a]dminister and supervise all forms of public assistance provided for by state law").

***3** Minnesota has long required MA recipients "to use their own assets to pay their share of the cost" for care. *Barg*, 752 N.W.2d at 61. The estate-recovery statute provides that, within one year after an MA recipient's death, DHS may record a notice of potential claim against property held by the estate in the records office of the applicable county. Minn. Stat. § 256B.15, subd. 1c(a)-(b). A notice of potential claim constitutes a lien on the property. *Id.*, subd. 1f(a). DHS, as the lien claimant, can recover MA costs through various mechanisms depending on the surviving status of the deceased recipient's relatives, if any. *See id.*, subds. 1h-1j.

Under federal law, an "estate" subject to Medicaid recovery "include[s] all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law." 42 U.S.C. § 1396p(b)(4)(A) (2018). Since 1993, federal law has also permitted states to expand the definition of "estate" for Medicaid recovery purposes to include:

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> *conveyed* to a survivor, heir, or assign of the deceased individual *through* joint tenancy, tenancy in common, survivorship, life estate, *living trust*, or other arrangement.

Id., (b)(4)(B) (emphasis added). Thus, a state may elect to recover assets that "under ordinary probate law, would not be part of the [decedent's] estate." *Barg*, 752 N.W.2d at 61.

In 2009, the Minnesota Legislature exercised this option and amended section 256B.15, subdivision 1a(b), to expand the definition of a decedent's estate for the purposes of MA recovery.[2] 2009 Minn. Laws ch. 79, art. 5, § 39, at 776-77. Today, section 256B.15, subdivision 1a(b)(5) provides, in relevant part, that a decedent's estate includes "*assets conveyed to a* survivor, *heir*, or assign of the person *through* survivorship, *living trust*, transfer-on-death of title or deed, or other arrangements." (Emphasis added.)

II.

DHS asks this court to reverse the district court's order on the ground that the commissioner correctly determined DHS could place the liens on the real property in the trust. DHS specifically argues that under section 256B.15, subdivision 1a(b)(5), the real property held in the trust is part of Margaret's estate because, absent the lien, the real property would pass to her heirs upon her death via a living trust.

DHS presents a question of statutory interpretation, which we review de novo. *Schmalz*, 945 N.W.2d at 49 n.3. The goal of statutory interpretation is to effectuate the intent of the legislature. Minn. Stat. § 645.16 (2022). The first step is to determine whether the language of the statute is ambiguous. *Olson v. Lesch*, 943 N.W.2d 648, 656-57 (Minn. 2020). "A statute is unambiguous if it has only one reasonable interpretation." *In re Welfare of Children of J.D.T.*, 946 N.W.2d 321, 327 (Minn. 2020). We afford some deference to an agency's interpretation "where the statutory language is technical in nature, and the agency's interpretation is longstanding." *Special Sch. Dist. No. 1 v. E.N.*, 620 N.W.2d 65, 68 (Minn. App. 2000). However, "we owe no deference to an agency's interpretation of an unambiguous statute." *Schwanke v. Minn. Dep't of Admin.*, 851 N.W.2d 591, 594 n.1 (Minn. 2014). When interpreting a statute, we read "words and phrases ... according to rules of grammar and according to their common and approved usage." Minn. Stat. § 645.08(1) (2022). When a statute does not define a legal term, we may look to legal definitions to determine the plain meaning of the term. *See Getz v. Peace*, 934 N.W.2d 347, 354-55 (Minn. 2019).

***4** As set forth above, Minnesota defines a person's estate for the purpose of MA recovery to include "assets conveyed to a[n] ... heir ... through ... [a] living trust." Minn. Stat. § 256B.15, subd. 1a(b)(5). Here, the parties do not dispute that the trust instrument created a living trust. *See Black's Law*

Dictionary 1821 (11th ed. 2019) (defining both "living trust" and "inter vivos trust" as "[a] trust that is created and takes effect during the settlor's lifetime"); *see also, e.g.*, *First & Am. Nat'l Bank of Duluth v. Higgins*, 293 N.W. 585, 590-92 (Minn. 1940). And the trust instrument explicitly provided that "[o]n the death of the survivor of the settlors, the trustee shall distribute all property then belonging to the income or principal of the trust to such person or persons out of a class composed of [the settlors'] descendants." Accordingly, the trust instrument provided that, upon Margaret's death, the real property would be conveyed to Margaret's heirs "through ... [a] living trust," as required for the real property be part of Margaret's "estate." *See* Minn. Stat. § 256B.15, subd. 1a(b)(5). Thus, the conveyance falls within the plain language of the statute. [3]

In response, Hammerberg makes three main arguments, which we address in turn. Hammerberg first argues that we cannot read the Minnesota statute so broadly because section 1396p(b)(4)(B), the federal authorizing statute, has narrower language. Hammerberg points to the parenthetical phrase, "(to the extent of such interest)," 42 U.S.C. § 1396p(b)(4)(B), arguing this language excludes conveyances via living trusts. We disagree. Hammerberg's interpretation of the federal authorizing statute is unreasonable when the parenthetical phrase is read in the context of the entire sentence. The federal authorizing statute provides that a state can define the estate to include:

> any ... real ... property ... in which the individual had any legal title or interest at the time of death (to the extent of such interest), *including such assets conveyed* to a[n] ... heir ... of the deceased individual *through* ... [a] *living trust.*"

42 U.S.C. § 1396p(b)(4)(B) (emphasis added). To interpret the parenthetical phrase to exclude conveyances via living trusts would render the language "including such assets conveyed to a[n] ... heir ... *through* ... [a] *living trust*" meaningless. *Id.* (emphasis added); *see also Am. Fam. Ins. Grp. v. Schroedl*, 616 N.W.2d 273, 277 (Minn. 2000) ("A statute should be interpreted ... to give effect to all of its provisions...."). Thus, we disagree with Hammerberg that the federal authorizing statute warrants a different result in this case.

Second, Hammerberg contends we should affirm the district court's order because DHS failed to identify the specific type of interest Margaret possessed in the real property at the time of her death. Again, we disagree. Neither the federal authorizing statute nor the Minnesota statute require DHS to identify the legal interest the individual possesses before placing a notice of potential claim on real property. *See* 42 U.S.C. § 1396p(b); Minn. Stat. § 256B.15, subd. 1a. Therefore, the commissioner did not commit reversible error when it failed to identify Margaret's legal interest in the real property held in the trust. [4]

***5** Third, Hammerberg argues that we should reverse the commissioner's decision because it failed to satisfy the standard set forth in *Barg*. We are unpersuaded. Initially, we question whether the standard in *Barg* applies to this case. In *Barg*, the supreme court addressed whether certain property was recoverable from a surviving spouse's estate, an issue not presented here. *See* 752 N.W.2d at 56, 59 n.5 (providing that the "discussion of spouses is premised on circumstances similar to those of the Bargs. One spouse, who we refer to as the recipient spouse, applies for and receives Medicaid benefits. The other, who we refer to as the community or surviving spouse, receives no Medicaid benefits and survives the recipient spouse").

But even if we assume *Barg* applies, Margaret's interest in the real property meets the *Barg* standard. Under *Barg*,

> for an interest to be traceable to and recoverable from a surviving spouse's estate, the interest must be (1) an interest recognized by law, (2) which the Medicaid recipient held at the time of death, and (3) that resulted in a conveyance of an interest of some value to the surviving spouse that occurred as a result of the recipient's death. [5]

Id. at 72. Principles of real property and probate law form the basis for determining whether someone has a legal interest in property at the time of their death. *See id.* For the purposes of estate recovery, "[a]t the time of death" means "a point in

time immediately before death." *In re Estate of Gullberg*, 652 N.W.2d 709, 713 n.1 (Minn. App. 2002).

We conclude the record shows that Margaret had a legally recognized interest in the real property held in the trust at the time of her death recognized under both real property and probate law. Based on real-property principles, Margaret possessed a qualified beneficial interest in the trust because she was entitled to use, possess, and collect any income from the property until her death. *See* Minn. Stat. § 501C.0103(m) (2022) (defining qualified beneficiary as, in relevant part, "a distributee or permissible distributee of trust income or principal"). This position granted Margaret the right to maintain suit against the trustee to, among other things, "compel the trustee to perform his duties as trustee," "enjoin the trustee from committing a breach of trust," and "compel the trustee to redress a breach of trust." *Morrison v. Doyle*, 582 N.W.2d 237, 243 (Minn. 1998) (quotation omitted). The trust instrument further provided Margaret with the power to unilaterally remove and replace the trustee.

Principles of probate law similarly indicate that Margaret possessed a legal interest in the real property at the time of her death. The trust provided Margaret with the right to determine through her will how the property would be distributed among her descendants upon her death. And under Minnesota probate law, a person can only devise by will an interest in property that they personally possess. *See In re Estate of Van Den Boom*, 590 N.W.2d 350, 353 (Minn. App. 1999) (applying this principle to probate proceedings), *rev. denied* (Minn. May 26, 1999).

For these reasons, we reverse the district court's decision on the ground that the commissioner correctly determined the real property held in the trust was subject to the liens under section 256B.15.

III.

***6** Finally, the parties dispute the proper disposition of this case. Hammerberg contends that, even if we conclude DHS properly recorded the liens on the real property held in the trust, we must remand to the district court because certain issues have been left unresolved. DHS asserts that reversal without a remand is appropriate because Hammerberg only challenged the validity of the liens. We agree with DHS.

Hammerberg requested, and DHS held, a fair hearing pursuant to Minn. Stat. § 256B.15, subd. 1f(c). There, the parties raised two issues: (1) whether Hammerberg timely challenged the liens and (2) whether DHS properly determined that the real property held in the trust was subject to the liens. Those issues have been resolved in this case. Thus, while questions may remain regarding the value of Margaret's interest and the collection of assets pursuant to the liens, those issues are outside the scope of this administrative appeal. *See N. Am. Water Off. v. LTV Steel Mining Co.*, 481 N.W.2d 401, 405 (Minn. App. 1992) (stating that, for agency decisions, we will not consider issues the parties raise "for the first time on appeal"). [6]

Therefore, we reverse the district court's decision and express no opinions on issues not properly raised before our court on appeal. [7]

Reversed.

All Citations

Not Reported in N.W. Rptr., 2024 WL 1712748

Footnotes

1 Because Leonard and Margaret share a last name, we refer to them by their first names for clarity.

2 Prior to 2009, section Minn. Stat. § 256B.15 did not include any reference to trusts. *See* Minn. Stat. § 256B.15, subd. 1a (2008) (referring only to the "estate" of the person in question).

3 We granted leave to the Elder Law Section of the Minnesota State Bar Association to submit a brief as amici curiae. *See* Minn. R. Civ. App. P. 129.01(a). Hammerberg and the amicus argue that only life estates and joint tenancies fall within the definition of an "estate" under section 256B.15. But Hammerberg and the

amicus describe the law as it existed before the legislature expanded the definition of "estate" for the purpose of MA recovery in 2009. *See* 2009 Minn. Laws ch. 79, art. 5, § 39, at 776-77. Today, section 256B.15, subdivision 1a(b), plainly contemplates that an individual's estate includes interests beyond life estates and joint tenancies.

4 The district court determined that the interest Margaret held was a license. *See Chicago & North Western Transp. Co. v. City of Winthrop*, 257 N.W.2d 302, 304 (Minn. 1977) (defining a license as "an interest in land in the possession of another which (a) entitles the owner of the interest to a use of the land, and (b) arises from the consent of the one whose interest in the land used is affected thereby, and (c) is not incident to an estate in the land, and (d) is not an easement" (quotation omitted)). This was error. Margaret's interest was not a license because she had the sole right to possess the real property held in the trust, and this right was neither dependent on the consent of the trustee nor revocable by the trustee.

5 With regard to the third element, as described above, this case does not involve the conveyance of an interest to a surviving spouse. In his brief, Hammerberg's only argument with respect to the third element is that no conveyance occurred because Margaret did not hold any legally recognized interest in the real property at the time of her death. Thus, we do not separately analyze the third element.

6 We also note that equitable claims are outside the scope of judicial review in an agency appeal. *See* Minn. Stat. § 14.69.

7 As an alternative basis for affirming the district court, Hammerberg contends that the commissioner used an unlawful procedure when it retroactively applied Minn. Stat. § 256B.15, subd. 1a(b)(5). But because neither the HSJ nor the district court considered or decided this argument, we decline to consider it. *See Thiele v. Stich*, 425 N.W.2d 580, 582 (Minn. 1988) ("A reviewing court must generally consider 'only those issues that the record shows were presented and considered by the [district] court in deciding the matter before it.' " (quotation omitted)).

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546 P.3d 684
Supreme Court of Idaho,
Boise, January 2024 Term.

State of Idaho, DEPARTMENT OF HEALTH AND WELFARE, Plaintiff-Respondent,
v.
Earle L. BEASON, an individual, Defendant-Appellant,
and
Mark Beason, an individual; Tom Beason, an individual; Ben Beason, an individual; Debbie Beason, an individual; The Estate of Juanita Gilbert, Deceased; The Estate of Robert E. Gilbert, Deceased; Jane Doe and John Doe, Defendants.

Docket No. 50302-2022
|
Opinion Filed: April 11, 2024

Synopsis

Background: Idaho Department of Health and Welfare brought action seeking to set aside a transfer of real property from two Medicaid recipients to five of their grandchildren, alleging the estates did not receive adequate consideration for the transfer of their interests in the real property. The Seventh Judicial District Court, Butte County, Darren B. Simpson, J., granted the Department's motion for summary judgment, and grandchild appealed.

Holdings: The Supreme Court, Zahn, J., held that:

four-year catch-all statute of limitation applied;

statute of frauds did not render agreement between Medicaid recipients and their grandchild inadmissible;

grandchild's statements in his summary judgment declaration concerning alleged agreement with Medicaid recipients to transfer property to him in exchange for injuries he had suffered as a child were inadmissible summary judgment evidence due to lack of foundation; and

grandchild's statements concerning his personal contributions to maintain Medicaid recipients' property were conclusory and did not create a genuine issue of material fact as to whether that his personal contributions to the property provided adequate consideration.

Affirmed.

Procedural Posture(s): On Appeal; Motion for Summary Judgment.

***687** Appeal from the District Court of the Seventh Judicial District of the State of Idaho, Butte County. Darren B. Simpson, District Judge.

The judgment of the district court is affirmed.

Attorneys and Law Firms

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Raúl R. Labrador, Idaho Attorney General, Boise, for Respondent. Douglas Fleenor argued.

Opinion

ZAHN, Justice.

This case concerns an action filed by the Idaho Department of Health and Welfare to set aside a transfer of real property from two Medicaid recipients, Robert Gilbert and Juanita Gilbert, to five of their grandchildren. During Robert's and Juanita's lives, the Department provided them with Medicaid benefits that totaled more than $140,000. In 2005, Robert and Juanita executed two quitclaim deeds transferring their interest in real property to themselves and their grandchildren. Juanita died in 2015, and Robert died in 2017.

Following their deaths, the Department filed this action to set aside the two quitclaim deeds. The Department alleged that Robert's and Juanita's estates did not receive adequate consideration for the transfer of their interests in the real property, which, under Idaho law, allowed the Department to set aside the transfers. One of the five grandchildren, Earle L. Beason, argued that the Department's action was barred by the statute of limitations and, in the alternative, that Robert and Juanita received adequate consideration for their interests in the property. The district court granted the Department's motion for summary judgment and entered a judgment in favor of the Department setting aside the quitclaim deeds after concluding that the Department's action was timely and that the Department had demonstrated the absence of a genuine issue of material fact regarding adequate consideration. Earle

L. Beason timely appealed. For the reasons discussed below, we affirm the district court's grant of summary judgment to the Department.

I. FACTUAL AND PROCEDURAL BACKGROUND

Robert owned real property in Butte County that he deeded to himself and his then-wife, Juanita, in 1990. In 2005, Robert and Juanita divorced. On the same day, Robert and Juanita executed two quitclaim deeds splitting the property and transferring their respective interests to themselves and their five grandchildren. The first deed transferred approximately half of the property to Juanita and the five grandchildren. The second deed transferred the remaining portion of the property to Robert and the five grandchildren. Both deeds state that Robert and Juanita transferred their respective interests "for valuable consideration received" but do not otherwise indicate what consideration they received in exchange for the transfers to their grandchildren.

Juanita received Medicaid benefits from 1996 until her death in 2015, totaling $137,023.29. Robert received Medicaid benefits from 2006 to 2008, totaling $3,248.31. Robert died in 2017. Robert's and Juanita's estates were probated shortly after Robert's death.

Federal law requires states participating in the Medicaid program to recover funds ***688** paid on behalf of certain individuals. *See* 42 U.S.C. § 1396p(b)(1). Pursuant to this requirement, Idaho law allows the Department to seek reimbursement for Medicaid benefits paid on behalf of an individual from that individual's estate. *See generally* I.C. § 56-218. Idaho law also allows the Department to set aside transfers of real property by Medicaid recipients if the transfers are not supported by adequate consideration. *See* I.C. § 56-218(2).

In late 2017, the Department filed a $137,023.29 claim for Medicaid benefits against Juanita's estate in the probate proceedings. On January 11, 2018, Earle R. Beason,[1] acting as the personal representative of Juanita's estate, served the Department with an affidavit and inventory of Juanita's estate. A "list of known claims" was attached to the affidavit, which included a claim by Earle L. Beason for an injury he suffered in 1988. The claims list stated that, while working on the property, Earle L. was severely injured and had to be life-flighted to the hospital, which resulted in substantial medical bills. The claims list also stated that Robert and Juanita did not have insurance but, "in taking responsibility," agreed to transfer the real property to the five grandchildren. Also attached to the affidavit was an inventory of Juanita's property, which identified real property in Butte County owned by Juanita and the five grandchildren. In early February 2018, the Department requested and obtained copies of the two quitclaim deeds that are the subject of this appeal.

On February 1, 2021, the Department filed this action against Robert's estate, Juanita's estate, and the five grandchildren to set aside the two quitclaim deeds. The Department alleged that Robert and Juanita received recoverable Medicaid benefits. The Department also alleged that Robert and Juanita transferred a portion of their interest in the real property to the five grandchildren without receiving any consideration in return. The Department, therefore, asserted that the two quitclaim deeds should be set aside pursuant to Idaho Code section 56-218(2).

All the defendants except Earle L. admitted in their answers that Robert and Juanita transferred the property to the five grandchildren without consideration. Earle L. denied that the 2005 transfer lacked adequate consideration. The Department and Earle L. then filed cross-motions for summary judgment. Earle L. argued that the Department's claims were barred by the applicable statute of limitation. The Department argued that there was not a genuine issue of material fact that Robert and Juanita transferred the property to the five grandchildren without consideration. The district court concluded that the Department's action was timely filed and that the Department had established there was no genuine issue of material fact that Robert and Juanita had transferred the property to their grandchildren without receiving adequate consideration. The district court therefore denied Earle L.'s motion for summary judgment, granted the Department's motion for summary judgment, and entered a judgment in favor of the Department setting aside the quitclaim deeds. Earle L. timely appealed.

II. ISSUES ON APPEAL

1. Whether the district court erred in concluding that the Department's action to set aside the quitclaim deeds was timely.

2. Whether the district court erred in granting the Department's motion for summary judgment.

III. STANDARDS OF REVIEW

"The determination of the applicable statute of limitations is a question of law[.]" *Berian v. Berberian*, 168 Idaho 394, 410, 483 P.3d 937, 953 (2020) (citation omitted). "Interpretation of a statute is a question of law." *Chester v. Wild Idaho Adventures RV Park, LLC*, 171 Idaho 212, 222, 519 P.3d 1152, 1162 (2022) (quoting ***689** *Idaho Dep't of Health & Welfare v. McCormick*, 153 Idaho 468, 470, 283 P.3d 785, 787 (2012)). "This Court exercises free review over questions of law." *Id.* (citing *Latvala v. Green Enters., Inc.*, 168 Idaho 686, 695, 485 P.3d 1129, 1138 (2021)).

"When reviewing an order for summary judgment, the standard of review for this Court is the same standard used by the district court in ruling on the motion." *Mendenhall v. Aldous*, 146 Idaho 434, 436, 196 P.3d 352, 354 (2008). "The court must grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." I.R.C.P. 56(a). "The burden of establishing the absence of a genuine issue of material fact rests at all times with the party moving for summary judgment." *Van v. Portneuf Med. Ctr.*, 147 Idaho 552, 556, 212 P.3d 982, 986 (2009). "When deciding a motion for summary judgment, '[a]ll disputed facts are to be construed liberally in favor of the non-moving party, and all reasonable inferences that can be drawn from the record are to be drawn in favor of the non-moving party.' " *Hilliard v. Murphy Land Co.*, 158 Idaho 737, 743, 351 P.3d 1195, 1201 (2015) (alteration in original) (citation omitted). "A mere scintilla of evidence or only slight doubt as to the facts is not sufficient to create a genuine issue of material fact for the purposes of summary judgment." *Jenkins v. Boise Cascade Corp.*, 141 Idaho 233, 238, 108 P.3d 380, 385 (2005). "If there is no genuine issue of material fact, only a question of law remains, over which this Court exercises free review." *Demoney-Hendrickson v. Larsen*, 171 Idaho 917, 921, 527 P.3d 520, 524 (2023) (citation omitted).

IV. ANALYSIS

A. The Department's set-aside action was timely filed pursuant to Idaho Code section 5-224.

Earle L.'s first argument on appeal is that the Department's action to set-aside the deeds was untimely. Determining the applicable statute of limitations requires us to analyze the estate recovery provisions of the Medicaid program. The Medicaid program is a cooperative endeavor between the federal and state governments in which the federal government provides financial assistance to participating states to aid them in furnishing health care to those in need. *In re Est. of Wiggins*, 155 Idaho 116, 119, 306 P.3d 201, 204 (2013) (citation omitted). "Under this program, States make legislation and rules, which are submitted to the U.S. Secretary of Health and Human Services for approval." *Id.* "The States receive federal payments for the program, but such payments are conditioned on various federal rules governing when and to what extent payments may be recovered from individuals." *Id.* (citing 42 U.S.C. § 1396p).

Relevant here, federal law requires states participating in the Medicaid program to recover funds paid on behalf of certain individuals. *See* 42 U.S.C. § 1396p(b)(1). This includes recovering funds from the estates of those who received Medicaid benefits while over the age of fifty-five. 42 U.S.C. § 1396p(b)(1)(B). Pursuant to this federal requirement, and pertinent here, Idaho enacted the Medicaid estate recovery scheme set out in Idaho Code section 56-218. Section 56-218(1) provides that the State may recover benefits paid to individuals over fifty-five from their estates. To that end, section 56-218(2) provides that "[t]ransfers of real or personal property ... by recipients of such aid, or their spouses, without adequate consideration are voidable and may be set aside by an action in the district court." We are charged here with determining the limitation period applicable to the Department's claims, pursuant to section 56-218(2), to set aside the two quitclaim deeds executed by Robert and Juanita.

The parties do not dispute that the Department's action to set aside the two quitclaim deeds accrued on January 11, 2018, which is the date that Earle R. provided the Department with the list of claims against Juanita's estate. The Department filed this action on February 1, 2021, just over three years after its cause of action accrued. The parties' arguments on appeal concern which of three statutes of limitation—Idaho Code sections 5-202, 5-218(1), or 5-224—applies to the Department's set-aside action.

***690** The Department contends that its claims are governed by Idaho Code section 5-202, which provides a ten-year limitation period for actions by the State for or in respect to real property by reason of the State's right or title to the property:

> The people of this state will not sue any person for or in respect to any real property or the issues or profits thereof,

> by reason of the right or title of the people to the same, unless:
>
> 1. Such right or title shall have accrued within ten (10) years before any action or other proceeding for the same is commenced; or,
>
> 2. The people or those from whom they claim, shall have received the rents and profits of such real property, or of some part thereof, within the space of ten (10) years.

I.C. § 5-202. Alternatively, the Department argues that its claims are governed by Idaho Code section 5-224, the catch-all statute of limitation, which provides a four-year limitation period when an action for relief is not otherwise provided for. The Department argues that its claims are timely under either statute.

Earle L. contends that the applicable statute of limitation is found in Idaho Code section 5-218(1), which provides a three-year limitation period for "[a]n action upon a liability created by statute, other than a penalty or forfeiture." Earle L. contends that this statute applies because the basis for the Department's claims is upon a liability created by statute—the right to set aside the transfers pursuant to section 56-218(2).

The district court concluded that section 5-202 provided the applicable limitation period because the Department's claims were "for or in respect to ... real property." The district court reasoned that section 5-218 did not apply because it excludes claims for a penalty or forfeiture, and the district court likened the Department's set-aside action to claims upon a penalty or forfeiture.

Earle L. argues that the district court erred in concluding that section 5-202 applies because the Department's set-aside action results from the Department's right to reimbursement for Medicaid benefits, not its "right or title" to the property. The Department argues that the district court correctly concluded that section 5-202 applies because a set-aside action is a claim with respect to real property. The Department also argues that section 5-218(1) cannot apply because a set-aside action is not an action upon a liability created by statute. The Department argues that, if the district court erred in concluding section 5-202 was the applicable statute, then the four-year catch-all limitation period in Idaho Code section 5-224 applies.

"The objective of statutory interpretation is to derive the intent of the legislative body that adopted the act." *Chester v. Wild Idaho Adventures RV Park, LLC*, 171 Idaho 212, 519 P.3d 1152, 1163 (2022) (quoting *Nelson v. Evans*, 166 Idaho 815, 820, 464 P.3d 301, 306 (2020)). Statutory interpretation begins with the literal language of the statute giving the words their plain, usual, and ordinary meaning. *See Access Behav. Health v. Dep't of Health & Welfare*, 170 Idaho 874, 881, 517 P.3d 803, 810 (2022) (citation omitted). "If the statute is not ambiguous, this Court does not construe it, but simply follows the law as written." *Chester*, 171 Idaho at 223, 519 P.3d at 1163 (quoting *Verska v. Saint Alphonsus Reg'l Med. Ctr.*, 151 Idaho 889, 893, 265 P.3d 502, 506 (2011)). "Statutory language is ambiguous where reasonable minds might differ or be uncertain as to its meaning." *Nordgaarden v. Kiebert*, 171 Idaho 883, 890, 527 P.3d 486, 493 (2023) (alteration omitted).

The "appropriate statute of limitations is determined by the substance, not the form, of the action." *Nerco Mins. Co. v. Morrison Knudsen Corp.*, 140 Idaho 144, 148, 90 P.3d 894, 898 (2004) (citation omitted). "[T]he focus in Idaho is not on the remedy sought or the type of damages, but on the source of the damages." *Doe v. Boy Scouts of Am.*, 159 Idaho 103, 105 n.3, 356 P.3d 1049, 1051 n.3 (2015).

We hold that the catch-all statute of limitation in section 5-224 applies to the Department's set-aside action because neither the plain language of section 5-202 nor ***691** section 5-218(1) is applicable to the Department's claims. Beginning with section 5-202, the plain language of that provision applies a ten-year limitation period to the Department's claims "for or in respect to any real property ... *by reason of the right or title of the people*[.]" (Emphasis added.) Section 5-202 only applies when the State has the right or title to the real property. For example, section 5-202 applies to actions by the State to quiet title. *See Ada Cnty. Highway Dist. v. Total Success Invs., LLC*, 145 Idaho 360, 368, 179 P.3d 323, 331 (2008). Although the Department's suit to set aside the two quitclaim deeds was an action "in respect to real property," the Department's claims filed in probate do not allege it has a right or title to the property nor do they seek to recover title to the real property. Rather, the relief it seeks is to set aside the quitclaim deeds so the real property is returned to Robert's and Juanita's estates, presumably so the Department can assert claims for reimbursement against those estates for the Medicaid benefits that Robert and Juanita received during their lifetimes. Accordingly, section 5-202 does not provide the applicable limitation period.

Section 5-218(1) also does not provide the applicable limitation period. Earle L. correctly notes that a "statutory liability" is liability "that depends for its existence on the enactment of the statute, and not on the contract of the parties." *State v. Ada Cnty. Dairymen's Ass'n*, 66 Idaho 317, 322, 159 P.2d 219, 220 (1945) (citation omitted). The Department may seek to set aside transfers because section 56-218(2) permits the Department to do so. Accordingly, section 56-218(2) creates a statutory liability for Medicaid recipients who transfer their real property without adequate consideration. *See id.*; I.C. § 56-218(2).

That said, section 5-218 excludes statutory liabilities for a penalty or forfeiture, and the substance of the Department's claims is a forfeiture action. Section 56-218(2) creates a right in the Department to set aside transfers of property, which results in divesting the transferee of his right to ownership. Although section 5-218(1) does not define "forfeiture," the divestiture sought here is synonymous with forfeiture. *See Forfeiture*, Black's Law Dictionary (11th ed. 2019) ("A judicial proceeding, the object of which is to effect a confiscation or divestiture."). Therefore, section 5-218 also does not provide the applicable limitation period.

When the limitation period on a claim is not otherwise provided for in another statute, the catch-all limitation period of section 5-224 applies. *Easterling v. HAL Pac. Props., L.P.*, 171 Idaho 500, 511, 522 P.3d 1258, 1269 (2023); *see also* I.C. § 5-224. Because neither section 5-202 nor section 5-218 provides the applicable limitation period, the four-year catch-all limitation period in section 5-224 applies to the Department's action. Although the district court erred in concluding that section 5-202 applied, it reached the right result because the Department's action was timely filed within the four-year limitation period of section 5-224. "Where an order of a lower court is correct, but based upon an erroneous theory, the order will be affirmed upon the correct theory." *State v. Hoskins*, 165 Idaho 217, 222, 443 P.3d 231, 236 (2019) (quoting *Andre v. Morrow*, 106 Idaho 455, 459, 680 P.2d 1355, 1359 (1984)). Accordingly, we affirm the district court's conclusion that the Department's action was timely under the right-result, wrong-theory rule. *See id.*

B. We affirm the district court's grant of summary judgment in favor of the Department because Earle L. did not establish a genuine issue of material fact regarding adequate consideration.

In opposition to the Department's motion for summary judgment, Earle L. asserted that he provided valuable consideration for his interest in the property. Earle L. alleged that a 1988 agreement, whereby Robert and Juanita agreed to transfer the property to avoid a lawsuit for injuries Earle L. sustained on the property, provided adequate consideration. He also alleged that contributions he made to maintain the property provided adequate consideration.

The district court granted summary judgment to the Department after concluding that Earle L. failed to establish a genuine issue of material fact as to whether Robert and Juanita received adequate consideration for the property interest conveyed to Earle ***692** L. The district court initially addressed the admissibility of evidence of the alleged 1988 oral agreement. The district court concluded that it could not consider evidence of the 1988 agreement because the agreement violated Idaho's statute of frauds. The district court concluded that the remainder of Earle L.'s evidence consisted of conclusory statements rather than specific facts and was, therefore, insufficient to establish a genuine issue of material fact regarding adequate consideration.

Earle L. argues that the district court "incorrectly analyzed the issue through the lens of the statute of frauds." He contends that there is no dispute that he acquired the property through a valid written deed rather than an oral agreement. Earle L. argues that his testimony regarding a 1988 agreement is evidence of the "valuable consideration" identified on the face of the deed. Earle L. argues that he established a genuine issue of material fact concerning adequate consideration based on the value of his personal injury claim and his contributions to maintaining the property.

We conclude that the district court erred in deciding that the statute of frauds rendered the 1988 agreement inadmissible but affirm its decision granting summary judgment because we agree that Earle L. failed to establish a genuine issue of material fact concerning whether Robert and Juanita received adequate consideration. The statute of frauds is not a rule of evidence even though it serves an evidentiary purpose. *See Hall v. Exler*, 170 Idaho 835, 842, 517 P.3d 96, 103 (2022) (citation omitted). Instead, it is a principle of substantive law that precludes the enforcement of certain types of contracts. *Tricore Invs., LLC v. Est. of Warren ex rel. Warren*, 168 Idaho 596, 622, 485 P.3d 92, 118 (2021) ("The statute of frauds does not prevent the creation of an oral contract but precludes the contract's enforcement." (citation omitted)); *see also* 73 Am. Jur. 2d *Statute of Frauds* § 384 (Feb. 2024 update) ("[A]lthough the statute of frauds is a bar to the enforcement of certain oral contracts, it does not preclude

the admission of evidence of an oral agreement for other purposes."). Indeed, the plain language of Idaho Code section 9-505, Idaho's codification of the statute of frauds, speaks to the validity of the agreement: "In the following cases *the agreement is invalid* ...." I.C. § 9-505 (emphasis added).

By applying the statute of frauds as an evidentiary rule, the district court overlooked that Earle L. is not seeking to enforce the 1988 agreement. Rather, Earle L. is alleging that the agreement is evidence that Robert and Juanita received adequate consideration for his interest in the property. The statute of frauds does not prohibit the introduction of evidence for this purpose and, therefore, the district court erred by refusing to consider Earle L.'s evidence of the 1988 agreement on that basis.

With that said, we affirm the district court's ultimate conclusion that the Department is entitled to summary judgment because Earle L. failed to establish a genuine issue of material fact concerning whether Robert and Juanita received adequate consideration. The Department met its initial burden of showing the lack of a genuine issue regarding adequate consideration. The Department alleged in its complaint that Robert and Juanita transferred the property for no consideration. Four of the grandchildren, as well as Earle R. on behalf of Juanita's estate, admitted in their answers that Robert and Juanita transferred the property without adequate consideration. This was sufficient for the Department to meet its initial burden of demonstrating the lack of a genuine issue, which then shifted the burden to Earle L. *See, e.g.*, *Franklin Bldg. Supply Co. v. Hymas*, 157 Idaho 632, 637, 339 P.3d 357, 362 (2014).

In response to the Department's motion, Earle L. submitted his own declaration, which asserts that he provided two forms of adequate consideration: (1) the alleged 1988 agreement whereby Robert and Juanita agreed to transfer the property to avoid a lawsuit for injuries Earle L. sustained on the property; and (2) Earle L.'s contributions to maintaining the property. Regarding the 1988 agreement, Earle L. explained that he was severely injured on the property when he was a child. He asserts that his parents, Earle R. and Tammy, "discussed [with Robert ***693** and Juanita] how to pay for the bills and reach[ ] an agreement." Earle L. states in his declaration that "Earle Ray and Tammy agreed that they would not sue Robert and Juanita if they agreed to turn the farm over to Ben Beason, Deborah Beason, Mark Beason, Thomas Beason, and myself. Robert and Juanita retained the right to live on and operate the farm until we were older." Earle L. then alleges that "[t]he property transfers on September 14, 2005, that are the subject of this action, were made, at least in part, to fulfill the 1988 Agreement."

Regarding contributions to maintaining the property, Earle L. states in his declaration that he "performed services on the farm in exchange for [his] property interests." Earle L. alleges that he repaired farm equipment and personally labored to improve the property. Earle L. also asserts that he contributed financially to maintaining the property. Earle L. estimates that he has "contributed an average of $6,500 of personal income per year into maintaining the farm in addition to 300 hours of unpaid labor on the farm each year when not serving in the Navy, as a sailor on ship at sea, or engaged in college classes." Earle L. states that these improvements to the property "were provided with the understanding that [he] would receive an interest in the farm in exchange for the services rendered."

We agree with the district court's conclusion that Earle L.'s declaration failed to establish a genuine issue of material fact on the issue of adequate consideration. "Summary judgment proceedings are decided on the basis of admissible evidence." *Oswald v. Costco Wholesale Corp.*, 167 Idaho 540, 564, 473 P.3d 809, 833 (2020) (quoting *Campbell v. Kvamme*, 155 Idaho 692, 696, 316 P.3d 104, 108 (2013)). Accordingly, "[t]he admissibility of evidence contained in affidavits and depositions in support of or in opposition to a motion for summary judgment is a threshold matter to be addressed before applying the liberal construction and reasonable inferences rule to determine whether the evidence creates a genuine issue of material fact for trial." *Fragnella v. Petrovich*, 153 Idaho 266, 271, 281 P.3d 103, 108 (2012) (citing *Gem State Ins. Co. v. Hutchison*, 145 Idaho 10, 13, 175 P.3d 172, 175 (2007)). "Declarations submitted on summary judgment 'must be made on personal knowledge, set out facts that would be admissible in evidence, and show that the ... declarant is competent to testify on the matters stated.' " *Mortensen v. Baker*, 170 Idaho 744, 753, 516 P.3d 1015, 1024 (2022) (quoting I.R.C.P. 56(c)(4)).

Earle L.'s statements in his declaration concerning the 1988 agreement are inadmissible due to lack of foundation. Earle L.'s declaration does not state that he was present for the discussions described in his declaration and he fails to explain how he has knowledge of the discussions or the purported agreement that his parents reached with Robert and Juanita. Accordingly, Earle L.'s statements that Robert and Juanita transferred an interest in the property to him in satisfaction of a claim he had for injuries suffered as a child are inadmissible.

Earle L.'s statements concerning his personal contributions to maintain the property do not establish a genuine issue of material fact because they are conclusory and fail to establish both the value of his contributions and an agreement with Robert and Juanita to transfer the property in exchange for his contributions. Earle L. explains in his declaration that he contributed time and effort to improve the property, but he provides little detail concerning the number of hours worked, what work was done, or the value of the hours worked. He also provides little detail concerning any items purchased for the property. Earle L. also alleges that he "performed services on the farm in exchange for [his] property interests" and that these services "were provided with the understanding that [he] would receive an interest in the farm in exchange for the services rendered." While it may be true that Earle L. made improvements and personally contributed to the property, he does not allege when he made the improvements and contributions or that he did so due to an agreement with Robert and Juanita to transfer an interest in the property in exchange for those contributions. As a result, Earle L.'s statements fail to establish that his personal contributions to the property provided adequate consideration. Because the Department met its initial ***694** burden, and Earle L. failed to establish a genuine issue of material fact in response, the Department was entitled to summary judgment on its claims to set aside the two deeds.

Our holding today is premised on Earle L.'s failure to provide any evidence of consideration in exchange for Robert's and Juanita's transfers of real property. As a result, we need not address the parties' arguments concerning the appropriate measure of "adequate consideration" for purposes of Idaho Code section 56-218(2).

V. CONCLUSION

For the reasons discussed herein, we affirm the district court's grant of summary judgment in favor of the Department. The Department is the prevailing party in this matter and, as such, is entitled to an award of costs pursuant to Idaho Appellate Rule 40.

Chief Justice BEVAN, and Justices BRODY, MOELLER, and MEYER concur.

All Citations

546 P.3d 684

Footnotes

1 Earle R. Beason is Juanita's son and the father of the five grandchildren, including Appellant Earle L. Beason. Earle R. was not a named defendant in the set-aside action and therefore is not a party to this appeal.

2024 IL App (1st) 230270

Appellate Court of Illinois, First District,
SECOND DIVISION.

IN RE MARRIAGE OF Rhonda V. MORIARTY, n/k/a Rhonda Jensen-Moriarty, Petitioner-Appellant,
and
Brad Lee Moriarty, Respondent-Appellee.

No. 1-23-0270
|
March 29, 2024

Synopsis

Background: Following divorce and termination of father's child support obligation for fourth child, mother filed petition for adult disabled child support for parties third child, who was diagnosed with autism spectrum disorder and other disabilities, pursuant to Marriage and Dissolution of Marriage Act. The Circuit Court, Cook County, Dominique C. Ross, J., denied petition. Mother appealed.

Holdings: The Appellate Court, Stanton-McBride, J., held that:

adult child was "not otherwise emancipated" within meaning of Act, and

as matter of first impression, mother's petition was timely filed.

Reversed and remanded.

Procedural Posture(s): On Appeal; Petition to Set Child Support.

Appeal from the Circuit Court of Cook County, 2012-D-000158, Honorable Dominique C. Ross, Judge Presiding.

Attorneys and Law Firms

Nicholaus J. Dilly and Simul S. Jhaveri, of Davis Friedman, LLP, of Chicago, for appellant.

No brief filed for appellee.

OPINION

JUSTICE McBRIDE delivered the judgment of the court, with opinion.

***1** ¶ 1 Pursuant to his divorce judgment with Rhonda Jensen-Moriarty, Brad Lee Moriarty made his last child support payment when the youngest of their four children was over 18 and had graduated from high school. Rhonda subsequently petitioned for adult disabled child support for their third child, who was then a 21-year-old high school graduate still residing with her mother and alleged to be incapable of ever living independently because of autism spectrum disorder and other disabilities. The circuit court denied the petition, finding that the child was "already emancipated" by virtue of her age and completion of high school. Rhonda contends this was a misinterpretation of the Illinois statute regarding nonminor disabled child support—section 513.5(a) of the Illinois Marriage and Dissolution of Marriage Act (Act) (750 ILCS 5/513.5(a) (West 2018)).

¶ 2 Rhonda and Brad married in 1988, separated in 2007, and divorced in 2012 by way of a judgment for dissolution of marriage which incorporated a marital settlement agreement (MSA). Rhonda was given sole care, custody, and control of the children, who were then ages 17, 14, 13, and 10. Article IV of the MSA addressed child support. Paragraph 4.1 required Brad to pay monthly child support until the youngest of the four "reached 18 along with having graduated from high school (whichever is later) or otherwise being emancipated as otherwise [*(sic)*] defined herein." The next paragraph in article IV stated:

> "4.2 TERMINATION OF CHILD SUPPORT: The child support obligation of BRAD to pay child support [*sic*] hereunder shall forever and wholly terminate upon the first to occur of the following events, which constitute 'emancipation' events for child support purposes:
>
> a) the youngest minor child graduating from high school;

b) the youngest minor child reaching the age of 18 as long as said child has graduated from high school;

c) the youngest minor child no longer residing in the residence of the mother on a permanent basis;

d) the youngest minor child beginning full-time employment other than during summer months while said child is working towards a secondary educational diploma; or

e) the death of a minor child, combined with the emancipation of all other minor children, as herein defined."

¶ 3 Article 7 of the MSA was titled "EMANCIPATION EVENT" and consisted of only one paragraph, which stated:

"7.1 Except for [the] child support situation, with its own definition of 'emancipation' as set forth in said Article, an 'emancipation event' for a child shall occur or be deemed to have occurred upon the earliest to happen of any of the following, at which time the [parties'] obligations for each individual child as detailed in this [MSA] shall terminate:

a. The child[ ] reaching majority ***;

b. The child's marriage;

c. The child[ ] having a permanent residence away from the permanent residence of RHONDA. ***

* * *

f. The child[ ] engaging in full-time employment ***."

¶ 4 It is undisputed that Brad was no longer required to make child support payments when he ended them in mid-2019.

***2** ¶ 5 Rhonda filed the petition at issue on September 29, 2019, when Lindsey, the third of the four children, was 21, contending that Lindsey required long-term financial support due to disabilities that dated to at least the age of six when she had been diagnosed with autism spectrum disorder. Rhonda alleged that Lindsey was also disabled by attention deficit hyperactive disorder, generalized anxiety disorder, and obsessive-compulsive disorder. She asked for financial support as well a resumption of the parties' obligations to maintain life insurance coverage that benefited Lindsey and to share the expenses of her uninsured medical, dental, optical, and mental health care. According to Rhonda's testimony in support of the petition, Lindsey had struggled since very early childhood with emotions, comprehension, and communication. At the suggestion of her first grade teacher, Lindsey received a neuropsychological evaluation. The testing resulted in her transfer to a different school for the second grade, where she received "special education services" pursuant to an individualized education plan (IEP) that was updated until Lindsey graduated from high school. Lindsey's IEP team recommended that she next attend the New Endeavors Transition program, to receive training in life skills and social skills, and assistance with job placement. While Lindsey was at New Endeavors Transition, a staff member of the Illinois Department of Human Services recommended her for part-time employment at an assisted living and nursing home, where she continues to work for $11.20 per hour as part of the waitstaff. Lindsey was declared disabled by the Social Security Administration and receives disability benefits of $29.74 per month. She has a disabled Illinois identification card (not a driver's license). She resides with her mother because she "does not have the capacity to be self-supportive now or in the future." When Rhonda sought estate planning assistance in 2018, she learned that Lindsey might qualify for nonminor child support due to her disabilities, and the petition at issue soon followed. Its resolution was delayed for several years. However, between July and December 2022, a domestic relations judge heard testimony and argument.

¶ 6 In addition to Rhonda's testimony, the court heard from Donna Woods, M.D., a board-certified child and adolescent and adult psychiatrist with 22 years' experience. Dr. Woods had been treating Lindsey for 12 years and was familiar with her IEPs and neuropsychological evaluations. She would see Lindsey as infrequently as every three months when she was stable but as often as every two weeks when "in a crisis." Their current appointments were approximately six weeks apart and were primarily for medication management. Dr. Woods testified that Lindsey's psychiatric and medical disorders are affecting her major life activities by making it difficult for her to care for herself and to learn, concentrate, communicate, and interact with others. She is incapable of maintaining a job "in a regular occupation" because she "can't take feedback," becomes belligerent and argumentative, and "explodes on people." She "really struggles with interacting with others" because she "doesn't get social cues," "doesn't have empathy," interrupts people in conversation, and talks "very rapidly." Autism causes her to be rigid about maintaining a routine, so that she will, for example, demand and scream at Rhonda to take her to a Starbucks coffee

shop on the way to work, even if the stop will make her late. Lindsey also lacks insight into the impact of her behavior, such that during their last appointment, Lindsey was screaming at Rhonda throughout and accusing her of falsely telling Dr. Woods that Lindsey was "very irritable," when in fact, Lindsey "has been struggling with emotional dysregulation and irritability and gets very reactive." Dr. Woods opined that Lindsey is unable to live independently because she can neither drive nor manage transportation on her own and is unable to cook, "understand money," or "pay her own bills." Also, Lindsey has been "disabled" since childhood within the meaning of the Act.

¶ 7 Brad's attorney cross-examined Rhonda and Dr. Woods but did not call other witnesses.

¶ 8 The judge denied Rhonda's petition in January 2023. The judge determined that Lindsey did not come within the terms of section 513.5(a), as that section authorizes support when the child "has attained majority [but] is mentally or physically disabled and not otherwise emancipated" (750 ILCS 5/513.5(a) (West 2018)), but Lindsey was already "21 years old and emancipated." Section 513.5(a) also specifies that "the disability that is the basis for the application for support must have arisen while the child was eligible for support under Section 505 or 513 of this Act." *Id.* Accordingly, the judge consulted section 505 of the Act (*id.* § 505), which is the general child support statute, and section 513 of the Act (*id.* § 513), which concerns educational expenses, but found that Lindsey did not qualify for support under either of those sections because she had "already [become] emancipated" by virtue of being "over the age of 19 and graduated high school" when Rhonda filed the petition. Lindsey was also emancipated within the meaning of the parties' MSA. Having found that the petition was "not timely filed," the circuit court did not reach the question of whether Lindsey was disabled within the meaning of the Act.

***3** ¶ 9 This is a case of first impression regarding the timing of a petition for adult disabled child support pursuant to section 513.5(a) of the Act (*id.* § 513.5(a)).

¶ 10 Rhonda completed her opening appellate brief in September 2023. In December 2023, when Brad had not responded, we ordered the case to be taken on the appellant's brief only. We will consider the merits of the appeal because the record is simple and the claimed error can easily be decided without the aid of an appellee's brief. *First Capitol Mortgage Corp. v. Talandis Construction Corp.*, 63 Ill. 2d 128, 133, 345 N.E.2d 493 (1976).

¶ 11 Rhonda's arguments about the meaning of the Act and the MSA pose questions of law, which we review *de novo*. *In re Marriage of Dynako*, 2021 IL 126835, ¶¶ 14-15, 452 Ill.Dec. 669, 186 N.E.3d 393. With statutory interpretation, the fundamental principle is to ascertain and give effect to the legislature's intent. *Id.* ¶ 14. The plain language of the statute is the best indication of that intent. *Id.* When statutory language is clear and unambiguous, a court may not depart from the plain language and meaning of the statute by creating exceptions, limitations, or conditions that the legislature did not express. *Id.* The court will examine the statute as a whole, considering all of its relevant parts. *In re Christopher K.*, 217 Ill. 2d 348, 364, 299 Ill.Dec. 213, 841 N.E.2d 945 (2005). Words and phrases are to be interpreted in light of any other relevant provisions of the statute. *In re Marriage of Edelman*, 2015 IL App (2d) 140847, ¶ 13, 395 Ill.Dec. 173, 38 N.E.3d 50.

¶ 12 Additionally, where the statute's language is clear and unambiguous, we will not resort to extrinsic construction aids. *Christopher K.*, 217 Ill. 2d at 364, 299 Ill.Dec. 213, 841 N.E.2d 945. Principles of contract interpretation govern the MSA. *Dynako*, 2021 IL 126835, ¶ 15, 452 Ill.Dec. 669, 186 N.E.3d 393; *In re Marriage of Sweders*, 296 Ill. App. 3d 919, 922, 231 Ill.Dec. 9, 695 N.E.2d 526 (1998). We ascertain the contracting parties' intent from the plain language of the MSA itself. *Sweders*, 296 Ill. App. 3d at 922, 231 Ill.Dec. 9, 695 N.E.2d 526. When MSA terms are unambiguous, they must be given their plain and ordinary meaning. *Id.* "A trial court has broad discretion in determining the necessity for and the amount of child support, and its decision will not be set aside unless the trial court abused its discretion or its order is contrary to the manifest weight of the evidence." *In re Marriage of Thurmond*, 306 Ill. App. 3d 828, 832, 240 Ill.Dec. 127, 715 N.E.2d 814 (1999); *In re Marriage of Mitchell*, 103 Ill. App. 3d 242, 249, 58 Ill.Dec. 684, 430 N.E.2d 716 (1981). A determination is contrary to the manifest weight of the evidence only when an opposite conclusion is clearly apparent or when the court's findings appear to be unreasonable, arbitrary, or not based upon the evidence. *In re Marriage of Romano*, 2012 IL App (2d) 091339, ¶ 44, 360 Ill.Dec. 36, 968 N.E.2d 115.

¶ 13 The provisions of the Act "do not extend the parental obligation for support beyond minority except in limited statutory situations" or "unless otherwise agreed in writing

or by court order." *Finley v. Finley*, 81 Ill. 2d 317, 326, 43 Ill.Dec. 12, 410 N.E.2d 12 (1980).

¶ 14 Section 513.5 is one of those rare exceptions for adult support, providing as follows:

> "Support for a non-minor child with a disability.
>
> (a) The court may award sums of money out of the property and income of either or both parties or the estate of a deceased parent, as equity may require, for the support of a child of the parties who has attained majority when the child is mentally or physically disabled and not otherwise emancipated. The sums awarded may be paid to one of the parents, to a trust created by the parties for the benefit of the non-minor child with a disability, or irrevocably to a special needs trust, established by the parties and for the sole benefit of the non-minor child with a disability, pursuant to subdivisions (d)(4)(A) or (d)(4)(C) of 42 U.S.C. 1396p, Section 15.1 of the Trusts and Trustees Act, and applicable provisions of the Social Security Administration Program Operating Manual System. [1] An application for support for a non-minor disabled child may be made before or after the child has attained majority. Unless an application for educational expenses is made for a mentally or physically disabled child under Section 513, the disability that is the basis for the application for support must have arisen while the child was eligible for support under Section 505 or 513 of this Act.
>
> ***4** (b) In making awards under this Section, or pursuant to a petition or motion to decrease, modify, or terminate any such award, the court shall consider all relevant factors that appear reasonable and necessary, including:
>
> (1) the present and future financial resources of both parties to meet their needs, including, but not limited to, savings for retirement;
>
> (2) the standard of living the child would have enjoyed had the marriage not been dissolved. The court may consider factors that are just and equitable;
>
> (3) the financial resources of the child; and
>
> (4) any financial or other resource provided to or for the child including, but not limited to, any Supplemental Security Income, any home-based support provided pursuant to the Home-Based Support Services Law for Mentally Disabled Adults, and any other State, federal, or local benefit available to the non-minor disabled child.
>
> (c) As used in this Section:
>
> A 'disabled' individual means an individual who has a physical or mental impairment that substantially limits a major life activity, has a record of such an impairment, or is regarded as having such an impairment.
>
> 'Disability' means a mental or physical impairment that substantially limits a major life activity." 750 ILCS 5/513.5 (West 2018).

¶ 15 This language codified Illinois decisional law indicating that a parent may be required to support a child who has attained majority but is mentally or physically disabled. See *In re Marriage of Kennedy*, 170 Ill. App. 3d 726, 732, 121 Ill.Dec. 362, 525 N.E.2d 168 (1988) (analyzing the statute when it was known as paragraph 513 rather than 513.5) (citing *Freestate v. Freestate*, 244 Ill. App. 166, 167 (1927) (regarding a parent's petition 10 years after divorce, seeking support for a 23-year-old child who had been "an invalid since she was two years old," the court found that support could be ordered if the parent made a sufficient showing on remand) and *Strom v. Strom*, 13 Ill. App. 2d 354, 367-68, 142 N.E.2d 172 (1957) (with respect to a parent's petition 12 years after divorce, seeking increased child support for a child who was disabled by polio, the court determined "it is the obligation of a parent of ample means to support a child incapable of self-support beyond the period of that child's minority" and to provide for that child's "care and education")). This support obligation has been codified since 1971. *In re Guardianship of Sanders*, 2017 IL App (4th) 160502, ¶ 17, 414 Ill.Dec. 82, 79 N.E.3d 717.

¶ 16 As just set out fully above, the first sentence of section 513.5(a) limits awards "as equity may require, for the support of a child of the parties who has attained majority when the child is mentally or physically disabled and not otherwise emancipated." We read this sentence to authorize support for a disabled child, provided that the person "has attained majority" and is "not otherwise emancipated." The arrival at majority age and emancipation are two distinct life events. However, as discussed below, the circuit court seems to have conflated Lindsey's age with emancipation because immediately after quoting the first sentence of section 513.5(a), the court concluded, "In this case, the adult child, Lindsey was 21 years old and emancipated." The court cited no statutory language which suggested that the General Assembly used the terms majority and emancipation

synonymously and cited no testimony or evidence about emancipation.

***5** ¶ 17 Majority age and emancipation have different meanings. Generally, a child will be considered emancipated "when he reaches the age of 18, at which time the child attains majority." *Sweders*, 296 Ill. App. 3d at 922, 231 Ill.Dec. 9, 695 N.E.2d 526 (citing *In re Marriage of Ferraro*, 211 Ill. App. 3d 797, 799-800, 156 Ill.Dec. 160, 570 N.E.2d 636 (1991)). However, a minor child may become emancipated under either the common law or by statute. *In re Marriage of Baumgartner*, 237 Ill. 2d 468, 479, 341 Ill.Dec. 510, 930 N.E.2d 1024 (2010). Illinois precedent indicates that a self-emancipated child is one who has not reached majority but is " 'physically and mentally able to take care of himself, [has] voluntarily abandon[ed] the parental roof and [left] its protection and influence, and [gone] out into the world to fight the battle of life on his own account.' " *In re Marriage of Donahoe*, 114 Ill. App. 3d 470, 475, 70 Ill.Dec. 152, 448 N.E.2d 1030 (1983) (quoting *Iroquois Iron Co. v. Industrial Comm'n*, 294 Ill. 106, 109, 128 N.E. 289 (1920)); see *In re Marriage of Walters*, 238 Ill. App. 3d 1086, 1091, 178 Ill.Dec. 176, 604 N.E.2d 432 (1992) ("It is clear that emancipation includes, but is not limited to, reaching the age of majority."). The statutory path to emancipation is through the Emancipation of Minors Act, whose stated purpose is to

> "provide a means by which a mature minor who has demonstrated the ability and capacity to manage [the minor's] own affairs and to live wholly or partially independent of [the minor's] parents or guardian, may obtain the legal status of an emancipated person with power to enter into valid legal contracts." 750 ILCS 30/2 (West 2018).

Similarly, a legal dictionary defines "Emancipation" as:

> "1. The act by which one who was under another's power and control is freed. 2. A surrender and renunciation of the correlative rights and duties concerning the care, custody, and earnings of a child; the act by which a parent (historically a father) frees a child and gives the child the right to his or her own earnings. *** This act also frees the parent from all legal obligations of support. Emancipation may take place by agreement between the parent and child, by operation of law (as when the parent abandons or fails to support the child), or when the child gets legally married or enters the armed forces." Black's Law Dictionary (11th ed. 2019).

¶ 18 Thus, broadly speaking, emancipation from one's parents occurs when one is able to care for oneself, live independently, and provide one's own financial support. There is no "bright-line standard" for emancipation, and "the unique facts and circumstances of each case must be evaluated." (Internal quotation marks omitted.) *Baumgartner*, 237 Ill. 2d at 480, 341 Ill.Dec. 510, 930 N.E.2d 1024.

¶ 19 The record indicates that Lindsey was "not otherwise emancipated" because, despite being of majority age, a high school graduate, and a part-time employee with accommodations by her employer, Lindsey is not " 'mentally able to take care of [her]self,' " and has not left the " 'protection and influence' " of her mother's home. *Donahoe*, 114 Ill. App. 3d at 475, 70 Ill.Dec. 152, 448 N.E.2d 1030 (quoting *Iroquois Iron Co.*, 294 Ill. at 109, 128 N.E. 289). Nor has Lindsey "demonstrated the ability and capacity to manage [her] own affairs and to live wholly or partially independent of [her] parents or guardian." 750 ILCS 30/2 (West 2018). Furthermore, the testimony about Lindsey's earnings indicates that she is not capable of supporting herself, given that she is not generally employable, works part-time for an employer that accommodates her disabilities but pays below minimum wage, and receives a monthly federal disability payment that is less than $30. The circuit court's finding that Lindsey "was 21 years old and emancipated" was contrary to the meaning of Act and the manifest weight of the evidence. By ruling based on Lindsey's age, the circuit court nullified the statutory phrase "not otherwise emancipated" and changed the meaning of the Act.

¶ 20 Briefly, the second sentence of section 513.5(a) restricts where the payments may be deposited. We may disregard this sentence because it does not speak to the issue of the timing of a parent's petition.

***6** ¶ 21 The third sentence allows an application to be filed "before or after the child has attained majority."

¶ 22 The concluding sentence of 513.5(a) indicates that "the disability *** must have arisen while the child was eligible for support under either Section 505 or 513 of this Act." 750 ILCS 5/513.5(a) (West 2018). The first of those two sections —section 505—is Illinois's general child support statute and authorizes support for "any child under age 18 and any child age 19 or younger who is still attending high school" (*id.* § 505(a)), and the other section—section 513—is specific to children's educational expenses "incurred no later than the

student's 23rd birthday, except for good cause shown, but in no event later than the child's 25th birthday" (*id.* § 513(a)). We read the fourth sentence to narrow awards to instances when a child's disability manifested while they were eligible either for general child support pursuant to section 505 or reimbursement of educational expenses pursuant to section 513. In our opinion, the fourth sentence is about the timing of a child's disability, rather than the timing of a section 513.5(a) application. The circuit court seems to have misconstrued this sentence as a limitation on the timing of Rhonda's petition by finding, "There is no provision contained within 750 ILCS 5/505 or 750 ILCS 5/513 that allows for the award of support from Respondent to Petitioner on behalf of Lindsey as an adult disabled child after Lindsey reached the age of 18 years or graduated high school by the age of 19 years." The circuit court erred because the fourth sentence was not about the timeliness of Rhonda's petition.

¶ 23 Although we quoted the full statute above, we are limiting our discussion to the four sentences in section 513.5(a). See *id.* § 513.5(a). We need not analyze the language of section 513.5(b), which lists factors the circuit court shall consider when making a section 513.5 award, such as the standard of living the child would have enjoyed had the marriage not been dissolved. *Id.* § 513.5(b). Nor do we need to contemplate section 513.5(c), which defines the terms " 'disabled' " or " 'Disability,' " neither of which affect the outcome of this appeal. See *id.* § 513.5(c).

¶ 24 Reading the first paragraph as a whole, along with the record, we find that Rhonda's petition for adult disabled child support (1) was appropriately timed, even after Lindsey's eighteenth birthday (consistent with the third sentence's specification that an "application for support for a non-minor disabled child may be made before or after the child has attained majority" (*id.* § 513.5(a))); (2) was concerning a disabling condition that Rhonda alleged arose during Lindsey's childhood (in conformance with the fourth sentence's limitation that "the disability that is the basis for the application for support must have arisen while the child was eligible for support under Section 505 or 513 of this Act" (*id.*)); and (3) sought support for an adult child who was "not otherwise emancipated" (satisfying the first sentence, which states, "The court may award sums of money out of the property and income of either or both parties or the estate of a deceased parent, as equity may require, for the support of a child of the parties who has attained majority when the child is mentally or physically disabled and not otherwise emancipated" (*id.*)).

***7** ¶ 25 We also find that the MSA was not relevant to the proceedings, because it was limited to Rhonda and Brad's obligations to their children due to their minority, but these proceedings concerned Rhonda and Brad's subsequent obligations to Lindsey due to a disabling condition that persisted from her minority to majority when she was not otherwise emancipated. Article 4 of the MSA, titled "CHILD SUPPORT," indicated that Brad's "obligation *** to pay child support *hereunder* shall forever and wholly terminate upon the first to occur of the following events." (Emphasis added.) Article 7 of the MSA, regarding "EMANCIPATION EVENT," specified that upon emancipation, "the [parties'] obligations for each individual child *as detailed in this Marital Settlement Agreement* shall terminate." (Emphasis added.) The parties' obligations under the MSA included, for example, maintaining the children's health insurance coverage. Articles 4 and 7 spoke of child support and emancipation within the bounds of the MSA. Neither article broached the topic of supporting any of the children into adulthood. If, by some stretch of the imagination the MSA did address Lindsey's need for child support as an adult, then those terms were not the final word on the subject. On page 19 of the MSA, Rhonda and Brad agreed, "E. *Except for those provisions concerning* custody, *child support* or welfare of the minor children, this Judgment *** and [MSA] shall not be modifiable by any subsequent Court of competent jurisdiction." (Emphasis added.) Thus, on page 19, the parties acknowledged that child support payments were subject to judicial modification. All in all, the MSA was not on point, and it was unnecessary for the circuit court to determine whether Lindsey was emancipated for purposes of the MSA or conclude, "There is no provision contained in the parties[']MSA that allows for support of Lindsey beyond [the date] when the parties[']youngest child *** reached the age of 18 years or graduated high school by the age of 19 years."

¶ 26 For these reasons, we vacate the dismissal of Rhonda's petition for disabled, nonminor child support as "not timely filed," and we remand for further proceedings consistent with this order.

¶ 27 Reversed and remanded.

Justices Ellis and Cobbs concurred in the judgment and opinion.

All Citations

--- N.E.3d ----, 2024 IL App (1st) 230270, 2024 WL 1340211

Footnotes

1 Because Rhonda petitioned on September 19, 2019, we are analyzing the version of the statute that was in effect until December 31, 2019. Subsequent minor revisions have been made to the statute but none of them affected the language at issue. In paragraph (a), as of 2020, the phrase "Section 15.1 of the Trusts and Trustees Act" was changed to "Section 1213 of the Illinois Trust Code" (Pub. Act 101-48, § 1608 (eff. Jan. 1, 2020) (amending 750 ILCS 5/513.5)), and then, effective 2022, "Section 1213 of the Illinois Trust Code" was changed to "Section 509 of the Illinois Trust Code" (Pub. Act 102-279, § 7 (eff. Jan. 1, 2022)). Also, effective 2022, in paragraph (a), the phrase "irrevocably to a special needs trust" was changed to "irrevocably to a trust for a beneficiary with a disability." *Id.*

2024 WL 1050325
Only the Westlaw citation is currently available.
United States District Court, D. Connecticut.

Brian CAVANAUGH, Plaintiff,

v.

Josh GEBALLE and Michelle Gilman, [1] Defendants.

CASE NO. 3:20-cv-981 (KAD)

|

Signed March 11, 2024

Attorneys and Law Firms

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Krislyn Mina Launer, Maria A. Santos, Office of the Attorney General, Hartford, CT, for Defendants.

MEMORANDUM OF DECISION

RE: MOTION TO DISMISS THE SECOND AMENDED COMPLAINT (ECF NO. 78) AND PLAINTIFF'S MOTION TO JOIN (ECF NO. 84)

Kari A. Dooley, United States District Judge:

***1** Plaintiff Brian Cavanaugh commenced this § 1983 action against Defendant Josh Geballe in his individual capacity and his official capacity as the Commissioner of the Department of Administrative Services ("DAS") of the State of Connecticut. Plaintiff originally sought declaratory and injunctive relief for violations of his federal statutory rights under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* ("Medicaid"), the Affordable Care Act ("ACA"), and his Fourteenth Amendment Due Process rights. By way of a Second Amended Complaint, Plaintiff now sues current DAS Commissioner Michelle Gilman in her official capacity and Josh Geballe in his individual capacity pursuant to 42 U.S.C. § 1983, alleging, *inter alia*, violations of 42 U.S.C. §§ 1396a & 1396p, the Due Process Clause of the Fourteenth Amendment, and the Takings Clause of the Fifth Amendment. His claims arise out of the Commissioner's past efforts to recoup medical expenses paid by the State on Plaintiff's behalf. Principally, Plaintiff seeks a permanent injunction precluding the Commissioner from pursuing $57,915 in said medical expenses and which were previously reflected in a lien placed by the Commissioner against Cavanaugh's interest in his grandmother's estate. He seeks a declaration that the medical debt is invalid. As discussed herein, the lien is no longer permitted under a recent change in state law and accordingly, has been removed by the Commissioner. Pending before the Court is the Commissioner's motion to dismiss on mootness grounds pursuant to Fed. R. Civ. P. 12(b)(1) and Fed. R. Civ. P. 12(b)(6) failure to state a claim. For the following reasons, the motion to dismiss is GRANTED and the motion to join is MOOT. (ECF Nos. 78, 84)

Facts and Procedural History

Plaintiff Brian Cavanaugh enrolled in HUSKY D, a Medicaid health insurance program provided by the Affordable Care Act and offered by the State of Connecticut, on October 3, 2011. Second Amended Complaint ("SAC") at 16 ¶ 39. From October 3, 2011, through November 16, 2011, Plaintiff received substance abuse and mental health treatment totaling $57,915.00 from the State of Connecticut at an institute for mental disease ("IMD"). SAC at 15–16, 18 ¶¶ 38, 49.

Years later, a probate proceeding commenced in the Connecticut State Probate Court for the District of Saybrook to administer the will of Cavanaugh's deceased grandmother, DiBirma Burnham. SAC at 18 ¶ 47. On March 29, 2019, the DAS Commissioner filed a statutory lien against Plaintiff's share of the estate for repayment of the medical services he received in 2011. *Id.* Thereafter, Plaintiff sued then-DAS Commissioner, Josh Geballe, in his official capacity, requesting, among other relief, a declaratory judgment that the Commissioner did not have a lien on his inheritance or his grandmother's estate and a permanent injunction enjoining the Commissioner from asserting the lien or enforcing Conn. Gen. Stat. §§ 17b-93, 17b-94, 17b-224, 18-85b, 46b-129, and 46b-130 in a manner that violates federal law. Compl. at 5 ¶¶ 26–27. [2]

***2** After remand from the Second Circuit and before Plaintiff filed a motion for leave to file an Amended Complaint, the state legislature amended Conn. Gen. Stat. § 17b-93, which now states:

> On and after July 1, 2022, the state shall not recover properly paid cash assistance, including by means of a lien filed on any real property, or a claim filed against property, a property

> interest or estate or claim of any kind, unless the state is required to recover such assistance under federal law or the provisions of this section. Any lien on real property or state claim against property, a property interest or estate or claim of any kind filed under this section by or on behalf of the state prior to July 1, 2022, shall be deemed released by the state if the recovery of such assistance is not required under federal law or the provisions of this section.

The lien on Plaintiff's inheritance falls into this latter category. The legislature also completely repealed Conn. Gen. Stat. § 17b-94, which had provided a mechanism for the State to impose a statutory lien on a beneficiary of aid for various state programs. [3] Accordingly, on July 13, 2022, the Commissioner withdrew the State's lien in the amount of $57,915.00 from the Probate Court because "the assistance that was received is no longer recoverable." Ex. D, ECF No. 69 at 47.

Recognizing that the lien is no longer in place, or even permitted under state law, Plaintiff now alleges in his Second Amended Complaint that DAS Commissioner, Michelle Gilman, in her official capacity, and Josh Geballe, in his individual capacity, violated 42 U.S.C. § 1983, 42 U.S.C. §§ 1396a & 1396p, the Due Process Clause of the Fourteenth Amendment, and the Takings Clause of the Fifth Amendment by "establishing a debt" totaling $57,915.00 on Plaintiff for medical assistance rendered to him in the fall of 2011 and seeks a declaratory judgment declaring such a debt a violation of his federal rights.

Standard of Review

Federal district courts are courts of limited jurisdiction under Article III, Section 2 of the United States Constitution. *See*, *e.g.*, *Chicot Cnty. Drainage Dist. v. Baxter State Bank*, 308 U.S. 371, 376 (1940). If subject matter jurisdiction is lacking, the action must be dismissed. *See* Fed. R. Civ. P. 12(h)(3) ("If the court determines at any time that it lacks subject-matter jurisdiction, the court must dismiss the action."). The Court may dismiss an action for lack of subject matter jurisdiction pursuant to Rule 12(b)(1) when the Court "lacks the statutory or constitutional power to adjudicate it." *Makarova v. United States*, 201 F.3d 110, 113 (2d Cir. 2000). "A plaintiff asserting subject matter jurisdiction has the burden of proving by a preponderance of the evidence that it exists." *Id.* "In resolving a motion to dismiss under Rule 12(b)(1), the [Court] must take all uncontroverted facts in the complaint ... as true, and draw all reasonable inferences in favor of the party asserting jurisdiction." *Tandon v. Captain's Cove Marina of Bridgeport, Inc.*, 752 F.3d 239, 243 (2d Cir. 2014).

***3** To survive a motion to dismiss filed pursuant to Rule 12(b)(6), "a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.' " *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 678. "The plausibility standard is not akin to a 'probability requirement,' but it asks for more than a sheer possibility that a defendant has acted unlawfully." *Id.* (quoting *Twombly*, 550 U.S. at 557). Legal conclusions and "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements," are not entitled to a presumption of truth. *Iqbal*, 556 U.S. at 678. Nevertheless, when reviewing a motion to dismiss, the court must accept well-pleaded factual allegations as true and draw "all reasonable inferences in the non-movant's favor." *Interworks Sys. Inc. v. Merch. Fin. Corp.*, 604 F.3d 692, 699 (2d Cir. 2010).

Discussion

Defendants have moved to dismiss the Second Amended Complaint in its entirety pursuant to Fed. R. Civ. P. 12(b)(5) (for lack of service on Geballe in his individual capacity), [4] 12(b)(1) (mootness & Eleventh Amendment sovereign immunity), and 12(b)(6) (failure to state a claim upon which relief can be granted). In partial response to the motion to dismiss, Plaintiff moved to join Geballe as a defendant in his individual capacity. This motion is moot however as Plaintiff already named Geballe as a defendant in his individual capacity in the Second Amended Complaint.

Plaintiff contends that this case is not moot because the debt should never have been established in the first place in violation of various federal statutes, to include Medicaid laws and the Affordable Care Act. Plaintiff seeks declaratory and injunctive relief to preclude the State of Connecticut from ever collecting on the debt and to render the debt invalid;

Plaintiff also requests money damages and attorney's fees and costs. SAC at 29 ¶ 87. Plaintiff clarifies in his brief that his requests for a declaratory judgment and injunctive relief are against state actors (presumably, Commissioner Gilman); his request for just compensation is against the State of Connecticut; [5] and his request for money damages, attorney's fees, and other such equitable relief is against Geballe in his individual capacity. P. Mem. in Opp. at 17.

Claims against Commissioner Gilman – 12(b)(1)

"Article III, Section 2 of the Constitution limits the jurisdiction of the federal courts to the resolution of 'cases' and 'controversies.' " *Mahon v. Ticor Title Ins. Co.*, 683 F.3d 59, 62 (2d Cir. 2012) (quotation marks omitted). "This limitation is 'founded in concern about the proper—and properly limited—role of the courts in a democratic society.' " *Id.* (quoting *Warth v. Seldin*, 422 U.S. 490, 498 (1975)). "A case becomes moot when it no longer satisfies the 'case-or-controversy' requirement of Article III[.] ... In order to satisfy this requirement, the [plaintiff] must, at all stages of the litigation, have suffered, or be threatened with, an actual injury which is likely to be redressed by a favorable judicial decision." *Marrero Pichardo v. Ashcroft*, 374 F.3d 46, 51 (2d Cir. 2004). "And if in the course of litigation, a court finds that it can no longer provide a plaintiff with any effectual relief, the case generally is moot." *Uzuegbunam v. Preczewski*, 141 S. Ct. 792, 796 (2021).

***4** In an analogous case, a District of New Jersey court held that a plaintiff's injunctive claims against a defendant who held subrogation and reimbursement liens on her settlement award were moot because the defendant withdrew the liens. *See West v. Health Net of the Northeast*, 217 F.R.D. 163, 175 (D.N.J. 2003). The court held that the voluntary cessation of challenge conduct exception to mootness did not apply because the defendant "irrevocably released any reimbursement and subrogation claims against plaintiff" because the liens were "void due to New Jersey laws." *Id.* (quotation marks omitted). Accordingly, the court dismissed the claims for injunctive relief as moot because the "withdrawal was unequivocal and complete" and plaintiff "was never required to pay any amounts because of the lien, and while she asserts that she bore 'incidental costs' associated with the lien, she has not presented any proof or explanation of these costs." *Id.* at 176. *See also Carey v. Inslee*, 364 F. Supp. 3d 1220, 1224 (W.D. Wash. 2019) (finding as moot plaintiff's claim for injunctive relief against "all future collection of agency fees from nonunion members" because the union "has already changed its policy to stop collecting fees" and the Supreme Court's decision in *Janus* "declared the relevant conduct unconstitutional"). The Court sees no reason why a different outcome should prevail here. Because DAS withdrew its lien, and Connecticut law now prevents DAS from reasserting that lien or otherwise recovering the cost of care, Plaintiff's claim is moot with no reasonable expectation that the alleged violation will recur. It would serve no useful purpose nor afford Plaintiff any relief to preclude that which the legislature has already precluded. All claims against Commissioner Gilman, sued only in her official capacity, are DISMISSED as moot. [6]

Claims Against Former Commissioner Geballe for Money Damages – 12(b)(6)

Defendants present several arguments in support of their request to dismiss the Second Amended Complaint for failure to state a claim. First, Plaintiff's purported debt does not derive from any federal statute. Second, the § 1983 claims fail because there are no facts alleging violations of federal rights or statutes by Geballe. Third, Plaintiff's deprivation of Due Process claims are devoid of facts. Last, Plaintiff has failed to state a plausible Takings Clause claim. The Court addresses each argument in turn.

Section 1983

"Section 1983 gives a cause of action to any person who has been deprived of his constitutional rights, privileges or immunities under color of state law." *Powell v. Workmen's Comp. Bd. of State of N. Y.*, 327 F.2d 131, 135 (2d Cir. 1964). Section 1983 " 'is not itself a source of substantive rights,' but merely provides 'a method for vindicating federal rights elsewhere conferred.' " *Graham v. Connor*, 490 U.S. 386, 393–94 (1979) (citing *Baker v. McCollan*, 443 U.S. 137, 144 & n.3 (1979)). "To prevail on a § 1983 claim, a plaintiff must establish that a person acting under color of state law deprived him of a federal right." *Thomas v. Roach*, 165 F.3d 137, 142 (2d Cir. 1999).

Claims Pursuant to the Affordable Care Act or Medicaid

The alleged debt—accepting as true that it is a debt and not simply a record of the cost of care the State rendered to Plaintiff—cannot have, as a matter of law, been created pursuant to Medicaid or the ACA. It is therefore axiomatic

that the debt cannot have been created in violation of either federal statutory scheme. Medical assistance as defined by Medicaid includes payments for cost of care for people who "are eligible for medical assistance." 42 U.S.C. § 1396d(a). Medicaid further defines and provides categories of individuals who are eligible for medical assistance under Medicaid. *See* 42 U.S.C. §§ 1396d(a)(i)–(xvii); *see also Waterbury Hosp. Center v. Sebelius*, No. 3:09-cv-1701 (RNC), 2012 WL 4512506, at *3 (D. Conn. Sept. 29, 2012) (Under § 1396d(a), " 'medical assistance' means payment of all or part of the cost of certain services to individuals eligible for Medicaid" and holding that because these particular participants "are ineligible for Medicaid, they are excluded by [the pertinent] definition."). Medicaid provides that medical assistance *does not* include "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases," also known as the IMD exclusion. 42 U.S.C. § 1396d(i)(B). "In other words, the statute prohibits the federal government from reimbursing any treatment in mental-health facilities (at least for beneficiaries between 21 and 64)." *Stewart v. Azar*, 313 F. Supp. 3d 237, 247 (D.D.C. 2018); *see also Northeast Hosp. Corp. v. Sebelius*, 699 F. Supp. 2d 81, 88 (D.D.C. 2010) (because the patients at issue "do not come within one of those thirteen categories of people eligible for Medicaid ... they cannot receive 'medical assistance' as that phrase is defined in the Medicaid statute.").

***5** While Plaintiff is correct that the ACA allowed states to expand Medicaid coverage, the ACA did not amend or otherwise repeal the IMD exclusion in § 1396d. Indeed, in 2015, the Health and Human Services Secretary began allowing states to apply for a § 1115 waiver that would allow states to be reimbursed for costs related to substance abuse programs. *See Stewart*, 313 F. Supp. 3d at 247–48. Connecticut did not receive a § 1115 waiver for substance abuse programs until 2022, eleven years after the State provided care to Plaintiff. *See Connecticut Substance Use Disorder Demonstration*, Medicaid, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/110976 (last visited Mar. 11, 2024); *Section 1115 Demonstration Waiver for Substance Use Disorder (SUD) Treatment*, Connecticut, https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project (last visited Mar. 11, 2024).

Indeed, prior to the § 1115 waiver, these mental health facilities could not "receive federal funding" for any treatment because of the IMD exclusion in § 1396d(i)(B). *Stewart*, 313 F. Supp. 3d at 247; *see also Brown v. District of Columbia*, No. 14-cv-750 (RC), 2022 WL 103304, at *2 (D.D.C. Jan. 11, 2022) ("Under the IMD exclusion, ... funds paid by the federal government to states for Medicaid expenditures—is generally unavailable for 'payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.' ").

Accordingly, Plaintiff's alleged debt, generated in 2011 when he was older than 21 and younger than 65 for substance abuse and mental health treatment that occurred at an IMD, and prior to Connecticut receiving a § 1115 waiver, could not have been created pursuant to Medicaid or the expenditure of federal funds. *See also Northeast Hosp. Corp. v. Sebelius*, 699 F. Supp. 2d 81, 88 (D.D.C. 2010) ("It is undisputed that the charity care patients do not come within one of those thirteen categories of people eligible for Medicaid.... Therefore, they cannot receive 'medical assistance' as that phrase is defined in the Medicaid statute."). "It is Congress's unambiguous definition of 'medical assistance,' not any purported inconsistent behavior by the Secretary or the [state], that controls." *Id.* at 90.

Accordingly, any § 1983 claim against Geballe predicated on the creation of the "debt" as a violation of Medicaid or the ACA fails to state a claim for which relief can be granted.

Due Process & Takings Clause Claims

Procedural "Due [P]rocess requires only that the state afford a party threatened with a deprivation of property a process involving pre-deprivation notice and access to a tribunal in which the merits of the deprivation may be fairly challenged." *Chase Group Alliance LLC v. City of New York Finance Department*, 620 F.3d 146, 151–52 (2d Cir. 2010). "If such a process is in place, due process is satisfied." *Id.* at 152; *see also Smith v. United States*, No. 3:11-cv-1996 (VLB), 2014 WL 902589, at *6 (D. Conn. Mar. 7, 2014) (explaining that prior precedent makes clear that Due Process rights are protected as long as plaintiff "was able to challenge the validity of the lien"). Here, Plaintiff received notice of the lien, had access to the tribunal in which the deprivation was challenged (the Probate Court), did so challenge (in the Probate Court and before this Court), and, ultimately, the lien was removed. As such, it cannot be said that Geballe violated

Plaintiff's procedural Due Process rights when the lien was originally placed in the Probate Court.

To plead a plausible substantive Due Process claim, a plaintiff must allege facts establishing (1) a cognizable property interest (2) that was invaded (3) in an arbitrary and irrational manner. *TZ Manor, LLC v. Daines*, 503 Fed. Appx. 82, 84 (2d Cir. 2012) (summary order); *O'Mara v. Town of Wappinger*, 485 F.3d 693, 700 (2d Cir. 2007); *see also O'Connor v. Pierson*, 426 F3d 186, 200 n.6 (2d Cir. 2005) (noting that substantive Due Process "is the right to be free of arbitrary government action that infringes a protected right"). Importantly, substantive standards of the Due Process Clause require "conduct that is so outrageously arbitrary as to constitute a gross abuse of governmental authority." *Natale v. Town of Ridgefield*, 170 F.3d 258, 259 (2d Cir. 1999). Conduct that is "merely incorrect or ill-advised" is insufficient to give rise to a substantive due process violation. *Ferran v. Town of Nassau*, 471 F.3d 363, 369–70 (2d Cir. 2006) (citation omitted; internal quotation marks omitted).

***6** Plaintiff does allege a sufficient property interest: his interest as a beneficiary of his grandmother's estate. *See Watrous v. Town of Preston*, 902 F. Supp. 2d 243, 259 (D. Conn. 2012) (explaining that "due process rights attach to even temporary or partial impairments of those [property] interests" including liens) (citing *Connecticut v. Doehr*, 501 U.S. 1, 11 (1991)). And placing a lien on that property interest would satisfy the "invasion" prong of a substantive Due Process claim. *Id.*

But Plaintiff's allegations as to nature of the arbitrary intrusion include only that he was forced into litigation to maintain his property rights in his deceased grandmother's estate and to "resurrect a past painful difficult health condition." SAC at 25 ¶ 74. Plaintiff inexplicably argues that Geballe is not in compliance with federal law and has "continued to maintain his illegal state enforcement of an illegal state debt." However, as noted, there is no longer any state enforcement of the lien (by Geballe or anyone), and likewise, there is no illegal state debt in violation of federal law because Plaintiff could not have been treated using Medicaid funds. Plaintiff has not therefore plausibly alleged that Geballe's conduct was "so outrageously arbitrary as to constitute a gross abuse of governmental authority." *Natale*, 170 F.3d at 259.

Any Takings Clause claim likewise fails, because a statutory lien is not a taking as a matter of law, and even if it was, the state never took any funds. *See Tchakarski v. United States*, 69 Fed. Cl. 218, 221–222 (2005) ("Although the court has jurisdiction over claims alleging a unconstitutional taking of private property, it does not have jurisdiction over the "takings claim" in this case, because, as a matter of law, a notice of a tax lien is not a taking."); *First Atlas Funding Corp. v. United States*, 23 Cl. Ct. 137, 139 (1991) (holding that a lien is merely a means of securing a position as a creditor and, therefore, the filing of a notice of a tax lien against a property interest does not state a takings claim). Accordingly, Plaintiff's procedural Due Process, substantive Due Process, and Takings Clause claims all fail for failure to state a claim as a matter of law.

Accepting as true Plaintiff's allegations, Plaintiff has failed to plausibly allege that Geballe, acting under color of state law, violated any federal law or infringed rights afforded to Plaintiff under the United States Constitution.

Conclusion

For the foregoing reasons, Defendants' motion to dismiss is GRANTED with prejudice. (ECF No. 78) Plaintiff's motion to join is MOOT. (ECF No. 84).

SO ORDERED at Bridgeport, Connecticut, this 11th day of March 2024.

All Citations

Slip Copy, 2024 WL 1050325

Footnotes

1 Pursuant to Fed. R. Civ. Pro. 25(d), Michelle Gilman is automatically substituted as Defendant for Plaintiff's official capacity claims because she was appointed Commissioner in February 2022.

2 The Court dismissed the Complaint for lack of subject matter jurisdiction pursuant to *Younger* abstention. *Cavanaugh v. Geballe*, No. 3:20-cv-981 (KAD), 2021 WL 781796 (D. Conn. Mar. 1, 2021). The Second Circuit

vacated the decision and remanded for further proceedings, holding that *Younger* abstention did not apply. *Cavanaugh v. Geballe*, 28 F.4th 428 (2d Cir. 2022).

3 Conn. Gen. Stat. § 17b-94(b) specifically provided for liens to be placed against an inheritance for aid previously paid under the state supplement program, medical assistance program, aid to families with dependent children program, temporary family assistance program, or state-administered general assistance program.

4 Plaintiff acknowledges that he never served Geballe in his individual capacity. Insofar as the Court dismisses the claims against this defendant under Rule 12(b)(6), the Court does not address whether or how untimely service should be permitted under Rule 4(m).

5 The State of Connecticut is not a defendant in this action and therefore any purported claim against the State of Connecticut is not further discussed.

6 To the extent Plaintiff seeks a declaratory judgment that the Commissioner violated Plaintiff's rights under federal law or the Constitution in the past, such relief is barred by the Eleventh Amendment. *See P.R. Aqueduct & Sewer Auth. v. Metcalf & Eddy*, 506 U.S. 139, 146 (1993) (Eleventh Amendment immunity "does not permit judgments against state officers declaring that they violated federal law in the past."); *Green v. Mansour*, 474 U.S. 64, 68, (1985) (same).

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82 Misc.3d 1207(A)
Unreported Disposition
(The decision is referenced in the New York Supplement.)
This opinion is uncorrected and will not be
published in the printed Official Reports.
Supreme Court, New York,
Broome County.

In the MATTER OF the Application of ELLEN H. and Scott H., Petitioners, Pursuant to Article 81 of the Mental Hygiene Law, for the Appointment of a Guardian of the Person and Property of Cassandra H., an Alleged Incapacitated Person.

Index No. 1984XXXXX
|
Decided on March 5, 2024

Attorneys and Law Firms

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Ellen H., pro se

Opinion

David H. Guy, J.

***1** This decision and order issues on a petition filed on October 11, 2023 by Mental Hygiene Legal Service (3rd Dept.) ("MHLS"), Jordan Charnetsky, Esq., of counsel. The petition asks the Court to surcharge Ellen H. in her capacity as the former trustee of the Cassandra H. Supplemental Needs Payback Trust, established by order of this Court dated July 11, 2003 ("SNT"). The petition is supported by a memorandum of law with two supporting exhibits, and the following exhibits to the petition: Exhibit A: 1986 case documents; Exhibit B: 2003 order appointing guardian; Exhibit C: Supplemental Needs Payback Trust Agreement; Exhibit D: Court Examiner affirmation; Exhibit E: letter from MHLS to Judge Guy; Exhibit F: decision and order; Exhibit G: order appointing court evaluator; Exhibit H: court evaluator report; and Exhibit I: order appointing successor guardian and trustee. Ms. H.; her sons, brothers of Cassandra and contingent remaindermen of her SNT; Broome and Tioga County Departments of Social Services, the relevant Medicaid counties; and the Executive Director of the agency that runs the home in which Cassandra resides were all on notice of the application. None filed any objection or response to the application.

The petition was returnable on November 16, 2023, at which time Ellen H. appeared; MHLS, Mr. Charnetsky, Esq., of counsel, appeared; and Kimberlee N. DeFazio, Esq., successor guardian/trustee for Cassandra H., appeared via Microsoft Teams. MHLS rested on their papers; Ms. H. neither filed nor stated any opposition to the petition; Ms. DeFazio filed no responding papers and expressed no position on the relief requested by MHLS.

For the reasons set forth herein, the Court grants the petition of MHLS and issues this decision and order finding Ellen H. failed to appropriately account for expenditures made by her from the resources of Cassandra H. and breached her fiduciary duty as the trustee of the SNT; and surcharging Ellen H. for her actions and inactions as the former trustee for and guardian of the person and property of Cassandra H.

PROCEDURAL HISTORY

In or about 1984, Ellen H. and Scott H. filed a personal injury action individually and as parents and natural guardians of Cassandra H., an infant at the time. The suit resulted in the entry of a settlement order dated October 24, 1986. The settlement order directed payment on behalf of and for the benefit of Cassandra H. in the amount a lump sum of $475,000; $2,000 per month, increasing at a rate of three percent (3%) per annum, compounded annually, after 4 years, for the remainder of Cassandra's life; [1] and periodic lump sums totaling $275,000, the last a $155,000 lump sum payment on November 1, 2016.

Ellen H. and Scott H. were appointed as guardians of the person of Cassandra H., pursuant to Surrogate's Court Procedural Act Article 17-A, by order of the Broome County Surrogate's Court dated April 19, 2002. They were later appointed as Co-Guardians of the Person and Property of Cassandra H., pursuant to Mental Hygiene Law Article 81, confirmed by order dated July 10, 2003, superseding and terminating the Surrogate's Court guardianship. The order establishing the Article 81 guardianship also directed the creation of the SNT for Cassandra's benefit. Cassandra's SNT

was executed on July 11, 2003 and appointed Scott H. and Ellen H. as trustees.

***2** On January 5, 2023, Broome County Court Examiner Jo A. Fabrizio, Esq., appointed by the Supreme Court, Appellate Division, Third Department to examine initial and annual Article 81guardianship reports required to be filed in Broome County pursuant to Mental Hygiene Law Sections 81.30 and 81.31, filed a motion alleging Scott H., who was by that point deceased, and Ellen H., as Co-Guardians of the Person and Property of Cassandra H., had not filed requested amended annual reports for the years 2016 and 2017 and had not filed any reports for the years 2018 through 2022, and seeking an order of the Court requiring compliance by the Co-Guardians with Mental Hygiene Law Section 81.31(a).

Ellen H. did not appear at the return on the compliance motion, and the Court appointed MHLS as counsel to locate and represent Cassandra H. in this matter, by order dated February 22, 2023.

The Court convened the next appearance in this matter on March 28, 2023, at which time Ms. Fabrizio appeared; MHLS, Mr. Charnetsky, Esq., of counsel, appeared; and Ellen H. appeared. Following this appearance, the Court issued an order dated March 28, 2023, terminating Ellen H.'s authority as guardian of the property of Cassandra H. That order also froze withdrawals from certain bank accounts held in the name of Ellen H. only, though Ms. H. purported to hold the funds in those accounts as fiduciary for Cassandra.

The Court convened this matter again on May 3, 2023, via Microsoft Teams, and Ms. Fabrizio appeared; MHLS, Mr. Charnetsky, Esq. appeared; and Ellen H. appeared. At this appearance, the Court determined that the appointment of a court evaluator would be helpful to the resolution of this matter, particularly in providing the Court with sufficient information regarding Cassandra H.'s past and current financial situation, as well as recommendations regarding the property management of the guardianship and Cassandra's SNT. The Court issued an order dated May 4, 2023 appointing Ms. DeFazio as Court Evaluator. Ms. DeFazio submitted her report to the Court and counsel on June 13, 2023.

The Court reconvened the matter on June 15, 2023 via Microsoft Teams, at which time Ms. Fabrizio appeared; Ms. DeFazio appeared; Mr. Charnetsky appeared; Ms. H. appeared; and Peter DeWind, Esq. and James Cornell appeared on behalf of the Tioga County Department of Social Services, an agency with a possible interest regarding the payment of Medicaid on behalf of Cassandra H. Ms. DeFazio testified regarding the contents of her report, and the report was admitted into evidence.

Based on the report, and all prior proceedings, pleadings, and orders in this matter, the Court found that Cassandra H. requires the appointment of a successor property guardian and trustee of her SNT. On the record, the Court removed Ellen H. as trustee of Cassandra's SNT. The Court also appointed Ms. DeFazio as Guardian of the Property of Cassandra H. and successor trustee of Cassandra's SNT. These findings and determinations were confirmed by written order of the Court dated June 28, 2023.

LEGAL STANDARD

A supplemental needs trust is a "discretionary trust established for the benefit of a person with a severe and chronic or persistent disability" that is designed to enhance the quality of the disabled individual's life by providing for special needs without duplicating services covered by Medicaid or disrupting or destroying Medicaid eligibility. EPTL 7-1.12(a)(5); *Cricchio v Pennisi*, 90 NY2d 296, 303 (1997). A first-party, or payback, special needs trust is funded with the assets belonging to a person with a disability and has four basic requirements: the trust contains the assets of the disabled individual; the trust is established for the benefit of the individual by the individual, a parent, grandparent, legal guardian, or court; the beneficiary is under 65 years old at the time of establishment; and the State will receive all amounts remaining in the trust upon the death of the individual for whose benefit the trust is created, up to an amount equal to the total medical assistance paid on behalf of the individual during the course of the beneficiary's life. 42 USC § 1396p(d)(4)(a).

***3** New York State requires that the trustee of a first-party supplemental needs trust follow certain rules in order to maintain the benefit qualifications of this type of trust. The regulations provide remedies to the local social services district if the trustee engages in acts or omissions in a manner inconsistent with the terms of the trust, contrary to applicable laws or regulations, or contrary to the fiduciary obligations of the trustee. 18 NYCRR 360-4.5(b)(5)(iv); *see also* Executive Law § 63(11).

Once established, the supplemental needs trust must be used for the benefit of the disabled individual. Social

Security Programs Operations Manual System ("POMS") SI 01120.201F.2; *Lopes v Dep't of Soc. Servs.*, 696 F3d 180, 186 (2d Cir 2012) (POMS provisions are entitled to "substantial deference, and will not be disturbed as long as they are reasonable and consistent with the statute."). Any provisions that provide benefits to other individuals or entitles during the disabled person's lifetime "will result in disqualification for the special needs trust exception." POMS SI 01120.201F.2. If the trustee uses funds from a trust that is a resource to purchase durable items, such as a car or a house, the deed or title must show the individual (or the trust) as the owner of the item in the percentage that the funds represent the value of the item, and failure to do so may constitute evidence of a transfer of assets in violation of the terms of the trust's terms. *Id.*

The Court is applying an abuse of discretion standard in analyzing the expenditures undertaken by the trustee in this matter. This analysis centers on three facts: whether the distribution from the trust was made for the primary benefit of the beneficiary; whether the trustee considered whether the distribution involved an expense that could have been paid by a governmental benefit program; and whether the trustee made the distribution despite the availability of a publicly funded option because the trustee determined the beneficiary's need would be better met by the distribution. EPTL 7-1.12(e).

In regard to a contested accounting proceeding, the fiduciary tasked with the accounting has the initial burden of proving she has fully accounted for the assets of the trust. *Matter of Curtis*, 16 AD3d 725 (3d Dept 2005). When a trustee has failed to keep or produce clear and accurate records and accounts, all adverse presumptions may be taken against the trustee. *Matter of Shulsky*, 34 AD2d 545 (2d Dept 1970). A fiduciary is required to employ a process of diligence and prudence in the care and management of the trust's assets and affairs as would prudent persons of discretion and intelligence in their own affairs. EPTL 11-1.7(a)(1); *Matter of Billmeyer*, 142 AD3d 1000 (2d Dept 2016). In a proceeding to settle an account, the court has broad discretion to make such order or decree as justice shall require, including surcharging the trustee with the amount of the inaccuracies in the accounting. *Schnare v Sutton*, 191 AD2d 859 (3d Dept 1993).

A fiduciary owes undivided loyalty to the beneficiary, and the fiduciary cannot place herself in a position where she has personal interests in conflict with the duties required by carrying out the fiduciary's role. *Matter of Estate of DePlanche*, 65 Misc 2d 501 (Sur Ct, New York County 1971). To warrant a surcharge, the fiduciary must be shown to have acted negligently or failed to exercise prudence in the management of the trust, resulting in a loss. *Matter of Donner*, 82 NY2d 574 (1983).

4 *FINDINGS OF FACT

The Court finds the following facts related to the relief sought in this unopposed application. Scott and Ellen H. executed Cassandra's SNT, which was established by court order, on July 11, 2003, and is a first-person supplemental needs payback trust. The trust names Scott and Ellen H. as trustees. The trust states:

> During the lifetime of [Cassandra H.], the Trust Fund shall be held, IN TRUST, for the benefit of [Cassandra H.] and shall be held, managed, invested, and reinvested by the Trustee in an account at HSBC Bank N.A. The Trustee shall collect the income therefrom and, after deducting all charges and expenses properly attributable thereto, shall, at any time and from time to time, apply for the benefit of [Cassandra H.], so much (even to the extent of the whole) of the net income and/or principal of this Trust as the Trustee shall deem advisable, in his or her or its sole and absolute discretion, subject to the limitations set forth below. The Trustee shall annually add to the principal of this Trust the balance of Net income not so paid or applied.

The trust directs that on Cassandra's death, the balance then remaining be paid back to New York State in an amount equal to the funds paid for Medicaid during Cassandra's lifetime. The language mirrors the POMS provisions discussed above, including provisions about the use of available governmental resources prior to expending trust resources on Cassandra's behalf.

Cassandra has been the recipient of monthly annuity payments for nearly 40 years. The payments are currently in excess of $5,000 per month and continue to increase at a rate

of three percent (3%) per annum compounded annually, for her lifetime. An initial and multiple subsequent lump sum payments have also been made pursuant to the settlement, with the most recent payment made in the amount of $155,000 on November 1, 2016. Ellen and Scott H., as trustees, were tasked with funding Cassandra's SNT with these annuity payments. The trust directs the funds be held at HSBC Bank, N.A., which initially occurred and continued for the first few years. HSBC Bank underwent several mergers, ultimately becoming KeyBank. In or about 2016, prior to his death in 2018, Scott H. switched the depository of the annuity payments to SEFCU. Since that time the funds have not been deposited into Cassandra's SNT but in accounts titled in Scott's and/or Ellen's names individually, with account nicknames of “Cassie's checking” and “Cassie's savings.”

Cassandra's SNT directs the trustees to file annual accountings for the trust. Ms. Fabrizio, as Court Examiner, was unable to approve as accurate and complete the guardianship and trust accountings provided to her by Ellen H. for the period of 2016 to 2022. A significant number of the payments from the trust in the accounts that were filed lack any indication or supporting information that they were made for legitimate trust expenses or applied for the benefit of Cassandra. The accountings contain numerous expenditures that are not itemized and are unsupported by reliable documentation, in the opinion of both the Court Examiner, who commenced this proceeding, and of the Court.

***5** The petition filed by MHLS alleges that during the period of 2016 through June 2023, the accounts held for Cassandra received a total of $574,965.49 in settlement payments from the annuity. During this entire period Cassandra resided in a Medicaid paid group home with supporting services. The Court has not received any information or documentation that refutes the information laid out by MHLS in its petition and supporting papers.

The Court Evaluator's report of June 13, 2023, referred to and incorporated by MHLS in its papers, establishes that the accounts held for Cassandra's benefit held a total of about $58,200 at that time, leaving $516,765.49 unaccounted for. The petition references and incorporates from the Court Evaluator's report approximately $200,000 in specific noted expenditures from the accounts held for Cassandra, including: payments on multiple automobile loans, none used primarily or substantially for Cassandra's benefit; several large payments on personal loans of Ellen and/or Scott H.; payments on a substantial RV loan at a time it was and could not have been used for Cassandra's benefit; transfers and expenditures made in Arizona and California while the trustees/guardians were in those states and Cassandra was in New York; unexplained cash withdrawals; expenses for a hot tub at Ellen's home during the Covid-19 pandemic, while Cassandra was unable to leave her group home; repaving of the driveway at Ellen's home in that same time period; car repairs; and miscellaneous shopping expenditures.

MHLS, on behalf of Cassandra H., objects to these expenses, arguing that there is no indication any of these expenditures were for Cassandra H.’s sole or primary benefit, as required by the terms of Cassandra's SNT and the rules and regulations governing first-person Medicaid payback trusts. MHLS asks the Court to surcharge Ellen H. in the amount of $516,765.49 for improper and unsupported expenditures made from Cassandra's funds during the period from 2016 through 2022.

The problematic payments raised in the Court Evaluator's report, which are the genesis of this motion, are an issue previously made clear to Cassandra's property guardians and trustees, Ellen and Scott H., nearly twenty years ago. In 2006, three years after Cassandra's SCPA Article 17-A guardianship was converted by the Supreme Court to the current MHLS Article 81 guardianship, improper expenditures from Cassandra's funds and reporting deficiencies were brought to the attention of Ellen and Scott H., with the involvement of their counsel. The guardians/trustees acknowledged their errors and committed to not repeating them, and yet the exact same malfeasance reoccurred. The nominal responses by Ellen H. during the course of the current inquiry have included her expression of lack of knowledge and understanding about her fiduciary duty to her daughter. The Court finds this beyond lacking credibility, and very relevant to the determination made here. It compels a finding of malfeasance, not misfeasance.

CONCLUSIONS OF LAW

Based on the foregoing, the Court finds that Ellen H. abused her discretion, in derogation of her fiduciary duty as trustee of the SNT, when she expended money from Cassandra's financial resources for payments on multiple automobile loans, personal loans, and an RV loan; purchases made while on vacation and/or trips where it is clear Cassandra was not present; numerous unaccounted-for cash withdrawals; hot tub maintenance; driveway repaving; car repairs, home repairs, and purchases of goods. These payments potentially threaten Cassandra's eligibility for public benefits, and it is clearly not in Cassandra's best interest to have her entitlement to

governmental benefits like Medicaid threatened in such a way. The Court finds that Cassandra H. was not the sole or primary beneficiary of the vast majority of the expenditures paid for with Cassandra's financial resources from the period of 2016 through June 2023.

***6** The express language of Cassandra's SNT is clear that the purpose is to supplement the financial needs of Cassandra H., so that she may have as fulfilling a life as possible, while still maintaining her eligibility for all public benefits she would otherwise be entitled to. The Court finds Ellen H. breached her fiduciary duty by using Cassandra's resources in a manner inconsistent with the terms of the SNT and Cassandra's needs as a person under a disability. The receipt and holding of Cassandra's assets in accounts not titled in the name of the guardianship or the trust is similarly a breach of Ellen's fiduciary duty.

The accountings provided by Ellen H. for the period of 2016 through 2022 are incomplete and do not contain sufficient information about the expenditures made with Cassandra's resources. MHLS, as petitioner on this application, has made the requisite showing to shift the burden to Ellen H., as the fiduciary, to prove that her accountings are accurate and complete. Ellen H. was unable to bring forth information or documentation indicating the accountings are accurate and complete or that the funds expended were used for Cassandra's primary or sole benefit. It is clear Ellen H. acted negligently and did not prudently exercise her authority and discretion as trustee or property guardian. Having failed to account properly or act in a prudent manner as fiduciary, Ellen H. is now surcharged for her actions and inactions as former trustee of the SNT and guardian of the property of Cassandra H.

The Court has carefully reviewed the supporting information from the petitioner, including the incorporated information from the Court Evaluator. Some expenditures are unquestionably improper. Some might be in some way helpful, in an ancillary or partial way, to Cassandra, but the burden of establishing that is on Ellen H., who has failed to put forth any rebuttal. A presumption against the appropriateness of the questioned expenditures is therefore applicable. Giving Ms. H. every reasonable benefit of the doubt after careful review, the Court finds that petitioner has established that a surcharge against Ellen H. in the amount of $450,000 is appropriate.

The Court acknowledges in rendering this decision that it is not finding that Ellen H. has failed to fulfill her responsibility as person guardian for Cassandra. That relief was not sought, despite the serious and substantial financial malfeasance evident here, and there is no indication that Ellen should not continue as person guardian for her daughter. The Court also recognizes that the travails and challenges of being the parent of a disabled child are immeasurable, beyond the true ken of the undersigned. Nonetheless, fiduciary duty applies.

This decision constitutes the order of the Court.

In furtherance of this decision, it is hereby

ORDERED, that the application of Mental Hygiene Legal Service (3rd Dept.) dated October 11, 2023 is granted; and it is further

ORDERED, that Ellen H. is surcharged in the amount of $450,000 for breach of her fiduciary duty as property guardian of Cassandra H. and trustee of the Cassandra H. Supplemental Needs Payback Trust, established by order of this Court dated July 11, 2003; and it is further

ORDERED, that judgement may be entered against Ellen H. in the amount of the surcharge rendered.

All Citations

Slip Copy, 82 Misc.3d 1207(A), 205 N.Y.S.3d 920 (Table), 2024 WL 1061733, 2024 N.Y. Slip Op. 50248(U)

Footnotes

1 The monthly payments are for the longer of a guaranteed period, now exceeded, and Cassandra's life.

82 Misc.3d 1207(A), 205 N.Y.S.3d 920, 2024 N.Y. Slip Op. 50248(U)

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540 P.3d 244
Supreme Court of Alaska.

In the MATTER OF the ESTATE OF Fe Perez ABAD
In the Matter of the Estate of Sandra Lee Boatner

Supreme Court Nos. S-18380, S-18450 (Consolidated)
|
December 22, 2023

Synopsis

Background: In separate actions, State filed reimbursement claims against estates of Medicaid recipients, seeking recovery for services provided prior to recipients' death. The Superior Court, Third Judicial District, Kodiak, No. 3KO-20-00057 PR, Stephen B. Wallace, J., disallowed State's claim, and the Superior Court, Fourth Judicial District, Fairbanks, No. 4FA-20-00520 PR, Earl A. Peterson, J., allowed State's claim. State and estate appealed respectively, and appeals were consolidated.

The Supreme Court, Borghesan, J., held that a claim by State against estate of a Medicaid recipient, seeking reimbursement for Medicaid services provided to recipient prior to recipient's death, arises before, rather than after, recipient's death, and therefore deadline under probate code for filing such a claim is within four months after notice to creditors, not four months after claim arose.

Decision of Superior Court, Third Judicial District, reversed; decision of Superior Court, Fourth Judicial District, affirmed.

Procedural Posture(s): On Appeal; Other.

Appeal in File No. S-18380 from the Superior Court of the State of Alaska, Third Judicial District, Kodiak, Stephen B. Wallace, Judge. Appeal in File No. S-18450 from the Superior Court of the State of Alaska, Fourth Judicial District, Fairbanks, Earl A. Peterson, Judge. Superior Court No. 3KO-20-00057 PR, 4FA-20-00520 PR

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Before: Maassen, Chief Justice, and Carney, Borghesan, and Henderson, Justices. [Pate, Justice, not participating.]

OPINION

BORGHESAN, Justice.

*245 I. INTRODUCTION

Under Alaska's probate code the deadline for filing a claim against a decedent's estate depends on when the claim arose. For claims arising "before the death of the decedent, ... whether due or to become due, absolute or contingent," the creditor must file within four months after the representative of the estate first published notice to creditors.[1] For claims arising "at or after the death of the decedent," the creditor must file within four months after the claim arose.[2] The question in these consolidated appeals is which deadline applies to the State's claim against the decedent's estate for reimbursement for Medicaid services provided to the decedent while alive.

We hold that Medicaid estate recovery claims arise before death and therefore must be filed within four months after notice to creditors. Although the State may not pursue these claims until after the Medicaid beneficiary has died, these claims arise when Medicaid services are provided, not when the claims become enforceable.

II. FACTS AND PROCEEDINGS

A. Statutory Framework

"The Medicaid program is 'a cooperative federal-state partnership under which participating states provide federally-funded medical services to needy individuals.' "[3] In determining who qualifies for Medicaid, federal law excludes the value of a person's home.[4] As a result some people receive Medicaid services despite owning a valuable asset. Congress addressed this "anomaly" by authorizing states to seek reimbursement for the cost of certain Medicaid services from the estates of deceased beneficiaries.[5] Estate

recovery was initially optional for state Medicaid programs. [6] But in the face of rapidly escalating Medicaid costs, Congress amended the law to require states to conduct estate recovery. [7] Because the State of Alaska has chosen to participate in Medicaid, it is obliged to comply with this federal statutory requirement. [8]

Accordingly the Alaska Legislature enacted AS 47.07.055, authorizing the State's Division of Health Care Services to seek reimbursement from the estates of deceased Medicaid recipients. Under this statute, "after an individual's death, the individual's estate is subject to a claim for reimbursement for [Medicaid] payments made on behalf of the individual ... to the extent that those services were provided when the individual was 55 years of age or older." [9] The claim "may be made only after the death of the individual's surviving spouse, if any," and only if the individual has no surviving child who is younger than 21, blind, or totally and ***246** permanently disabled. [10] Regulations adopted under AS 47.07.055 provide that the State will pursue estate recovery claims only if "the potential recovery amount would result in twice the administrative and legal cost of pursuing the claim, with a minimum pursuable net amount of $10,000." [11] The State may also waive estate recovery where it would cause undue hardship. [12]

B. Abad Proceedings

Fe Perez Abad passed away on August 19, 2020 after receiving Medicaid home and community-based services. Her daughter opened an informal probate case approximately two months later and was appointed the personal representative of Abad's estate. Abad's estate issued its first notice to creditors on October 19, 2020. On December 30, 2020 — less than four months after the estate published its first notice to creditors, but more than four months after Abad's death — the State filed a claim against the estate for $200,621.62 in Medicaid reimbursement. The estate disallowed the State's claim.

The State then petitioned the superior court to allow its Medicaid reimbursement claim. The estate objected, arguing the claim was time-barred. The estate reasoned that because the claim could be asserted only against Abad's estate, and not against Abad herself while alive, the claim arose at the time of Abad's death for purposes of AS 13.16.460. Because the claim had not been filed within four months of her death, the estate argued, it was untimely. The State argued that its claim arose before Abad's death, triggering the "before death" notice-based filing deadline under AS 13.16.460. Accordingly, the State argued, it was timely because it was filed within four months of when notice to creditors was first published.

The superior court agreed with the estate, holding that the State's Medicaid recovery claim did not arise during Abad's lifetime and should have been brought within four months of her death. Noting that no published Alaska decision addressed the interaction of AS 47.07.055 and AS 13.16.460, the superior court examined decisions from the Nebraska, Iowa, and Washington supreme courts. The superior court also rejected the State's policy argument that a deadline tethered to death, rather than notice to creditors, would hamper the State's ability to pursue estate recovery in accordance with federal law.

The State filed a motion for reconsideration, which the superior court denied.

The State then appealed.

C. Boatner Proceedings

Sandra Lee Boatner passed away on September 1, 2020. During her life she was the beneficiary of Medicaid services. Roughly two months after her death, David E. Cook opened an informal probate case; he was appointed the personal representative of her estate. The estate issued its first notice to creditors on December 22, 2020. On March 24, 2021 — less than four months after the estate published its first notice to creditors, but more than four months after Boatner's death — the State filed a claim against the estate for $300,647.29 in Medicaid reimbursement.

In May of that year the estate disallowed the claim, maintaining that it was not timely filed. The State petitioned the superior court to permit its claim against Boatner's estate, asserting that its claim was timely filed under AS 13.16.460(a)(1). The parties each moved for summary judgment. Their arguments paralleled those in the *Estate of Abad* litigation.

A standing master recommended that the superior court adopt the State's reading of Alaska's probate filing deadlines. The standing master acknowledged that Medicaid estate recovery claims become enforceable after death. But because these claims concerned medical expenses that Boatner incurred during her lifetime, the standing master concluded they arose before her death. The superior court adopted the standing master's recommendation.

***247** Boatner's estate filed a motion for reconsideration, and the superior court denied it. The court explained that the State seeks to recover debt arising from medical expenses, and that "[a]ll medical expenses occur while the person is still deemed alive." The court further explained that the provision of AS 47.07.055(a) limiting recovery until after the recipient's death "does not shift the accrual date" or "change the fact that the person still received that care during her lifetime." Rather, the court described this provision as "an offer of grace for the benefitted person to live out her life without worry of being refused care for lack of payment."

Boatner's estate appealed. We consolidated the Boatner estate's appeal with the Abad estate's appeal for purposes of oral argument and decision.

III. DISCUSSION

These two cases present a single question of statutory interpretation: For purposes of the probate code's claim filing deadlines under AS 13.16.460, does a Medicaid estate recovery claim under AS 47.07.055(e) arise "before death" or "at or after death"? The answer determines the deadline for the State to present its claim for reimbursement to the estate.

Statutory interpretation is a question of law that we review de novo.[13] "We apply our independent judgment to the interpretation of Alaska statutes and will interpret statutes 'according to reason, practicality, and common sense, taking into account the plain meaning and purpose of the law as well as the intent of the drafters.' "[14] "Statutory interpretation begins with the plain meaning of the text, but it does not stop there."[15] Instead, we subscribe to a "sliding scale approach to statutory interpretation,"[16] under which "[t]he plainer the statutory language is, the more convincing the evidence of contrary legislative purpose or intent must be."[17]

We conclude that Medicaid estate recovery claims arise before death for purposes of the probate code's filing deadline. This conclusion is supported by statutory text, the underlying legislative purpose of the Medicaid estate recovery statute, and the weight of precedent from other jurisdictions.

A. Statutory Text Suggests That Medicaid Estate Recovery Claims Arise Before A Beneficiary's Death Even Though They Cannot Be Enforced Until After Death.

The estates emphasize the text of the estate recovery statute. They argue that because the State may bring a Medicaid estate recovery claim only "after an individual's death" and only against the deceased individual's estate,[18] the State's claim for reimbursement arises "at or after" the individual's death.[19] The State instead emphasizes the text of the probate code. It points out that the probate code refers to when claims "arise," rather than when they "accrue," and recognizes that claims arising before death include those that are "due or to become due, absolute or contingent."[20] Accordingly the State argues that a Medicaid estate recovery claim arises when the services are provided to the beneficiary, even if it is not enforceable and therefore remains contingent until the beneficiary's death. The State also asserts that other language in the probate code ***248** suggests that claims arising "at or after" death are related to estate administration, rather than to obligations incurred by the beneficiary while alive. The State's position is ultimately more persuasive.

The probate code's use of "arise" rather than "accrue" does not, on its own, resolve the dispute. According to the State, a claim *arises* when the underlying events take place, but a claim only *accrues* when it is enforceable. Yet the dictionary does not suggest such a clear distinction between these terms.[21] The Revised Fourth Edition of Black's Law Dictionary, which would have been available to the legislature when it enacted AS 13.16.460, states that "[a] cause of action 'accrues' when a suit may be maintained thereon" or "[w]henever one person may sue another."[22] The entry for "arise" notes that the term is not a synonym for "accrue."[23] It defines "arise" as "[t]o spring up, originate, to come into being or notice, to become operative, sensible, visible, or audible; to present itself."[24] This definition tends to support the State's position, as the Medicaid estate recovery claim "came into being" or "originated" with the provision of Medicaid services. But Black's Law Dictionary also states that a cause of action or suit " 'arises,' so as to start running of limitation, when a party has a right to apply to the proper tribunal for relief."[25] Because AS 13.16.460 is a statute of limitation, this second definition of "arise" is more on-point and therefore tends to support the estates' position.

However, the legislature's decision to explain that a claim may arise whether it is "due or *to become* due" and whether "absolute or *contingent*" favors the State's position.[26] These qualifiers suggest that the legislature meant that a claim might arise even before the claimant could enforce it. A "contingent

claim" is, according to Black's, "[o]ne which has not accrued and which is dependent on some future event that may never happen."[27] This language supports the conclusion that a claim may "arise" before it becomes enforceable. A Medicaid estate recovery claim, though contingent and unenforceable before the beneficiary's death and the death of a surviving spouse, can therefore fall in the category of claims arising before death.

The probate code's definition of "claim" reinforces the conclusion that Medicaid estate recovery claims arise before death for purposes of AS 13.16.460(a)(1)'s filing deadline. The probate code defines "claims" in a way that mirrors AS 13.16.460's distinction between claims arising before death and claims arising "at or after" death.[28] " '[C]laims,' in respect to estates of decedents," include both "liabilities of the decedent ..., whether arising in contract, in tort, or another way, and liabilities of the estate that arise *at or after* the death of the decedent ..., including funeral expenses and expenses of administration."[29] A Medicaid estate recovery claim is akin to a contract claim: in exchange for receiving services, the beneficiary incurs a contingent obligation to repay after death, with funds from the beneficiary's estate. It is far less similar to "funeral expenses and expenses of administration," the kinds of claims the statute offers as ***249** examples of claims arising at or after death.[30]

Secondary sources support this distinction and confirm that Medicaid estate recovery claims fall in the category of claims arising before death for probate purposes. Richard Wellman's Uniform Probate Code Practice Manual, which we have found useful in the past,[31] explains that claims that "arise at or after death" are "commonly classified as expenses of administration."[32] The Stein on Probate treatise agrees, explaining that "[b]ecause claims arising after death usually originate from acts by the personal representative, they occur primarily during administration."[33]

The Stein treatise illustrates the distinction between claims arising before death and claims arising after death with helpful examples.[34] Before-death claims include "last illness charges, charges for illness during the year immediately preceding death, personal service charges during lifetime, recovery on warranties, liability as a surety or guarantor, claims of the state or county for support in state or county mental institutions, equitable claims, and other general contract claims."[35] Claims that arise after death include "accountants' fees, representative's and attorneys' fees, repair and maintenance expenses of property of the estate, insurance premiums, storage costs, platting costs, and charges for all services rendered to the personal representative for the estate."[36] Medicaid estate recovery claims, which are based on healthcare costs incurred prior to a recipient's death rather than estate administration expenses, are similar to the kinds of claims that the treatise describes as claims arising before death.

B. Classifying Medicaid Estate Recovery Claims As Claims Arising Before Death Is More Consistent With Legislative Purpose.

The parties argue that their respective interpretations are more consistent with the purposes underlying the probate code and the Medicaid statutes. The estates argue that classifying Medicaid estate recovery claims as claims arising at or after death will cause the claims to be asserted earlier, furthering the goal of speedier estate administration. The State does not agree that classifying probate claims this way will necessarily expedite probate administration. It also argues that subjecting Medicaid estate recovery claims to a potentially more restrictive filing deadline is inconsistent with the priority the Legislature has assigned these claims vis-à-vis the claims of other creditors.[37] Again we find the State's arguments on these points more persuasive.

Alaska's probate statutes are intended to "promote a speedy and efficient system for liquidating the estate of the decedent"[38] and "facilitate the prompt settlement of estates,"[39] among other purposes. Abad's estate contends that treating Medicaid estate recovery claims as arising at or after death would expedite probate administration. Generally, the decedent's heirs and creditors have up to three years after death to open a probate proceeding.[40] The estates argue that if the State's claim arises "at or after" death, then its claim will expire unless filed within four months after death.[41] If by that time no one has stepped forward to administer the decedent's ***250** estate, then the State will be forced to seek appointment as the personal representative of the estate in order to preserve its claim.[42] Accordingly, the estates argue, the probate process will unfold more quickly, which is more consistent with the goal of the probate code.

Though the estates' theory may be correct in some cases, it is not universally true. In other cases treating Medicaid estate recovery claims as arising at or after death could prolong

estate administration. For example, a claim cannot be made against the decedent's estate if there is a surviving spouse or child under 21.[43] If a Medicaid estate recovery claim does not arise until it becomes enforceable, then the claim could arise several years after the beneficiary's death, upon the death of the surviving spouse or the 21st birthday of a child. If the estate were still in the process of probate, the State would have four more months from that point to present its claim, even if all other creditors' claims had been filed long ago. For that reason classifying Medicaid estate recovery claims as arising at or after death does not necessarily mean that the probate process will unfold more quickly. The uncertain and marginal effect on the speed of probate administration is not a persuasive reason to interpret Medicaid estate recovery claims as arising at or after death when the statutory text clearly places them in the category of claims arising before death.

The State argues that classifying Medicaid estate recovery claims as arising before death furthers the underlying purpose of estate recovery: "recovering from those with an ability to pay so as to make future funds available for those having the most need."[44] Abad's estate essentially argues that federal legislative intent is irrelevant because the Alaska legislature passed AS 47.07.055 to comply with federal requirements and access federal Medicaid funding — not necessarily to recover costs. But in order to access federal funding, Alaska needed a program that effectuates the federal act.[45] We must assume that legislature's purpose was consistent with that of the federal law it implemented.

Interpreting Medicaid estate recovery claims as arising at or after death would undermine this legislative purpose by making it more expensive to pursue estate recovery. It is true, as the estates point out, that the State could prevent its claim from expiring four months after death by applying to be the personal representative within that time. But doing so would require the State to incur additional costs in administering the decedent's estate. These additional costs would diminish the State's net recovery, undermining the goal of recovering funds to be made available for other needy people.

***251** Classifying Medicaid estate recovery claims as arising at or after death would also subject the State to a risk of nonrecovery not faced by other creditors. One reason creditors whose claims arise before death are given four months from the date on which the estate publishes notice to creditors is that these creditors may not be aware that the person who owes them money has died:

> It is foreseeable that holders of [pre-death] contractual claims may be unaware of the death of the decedent and thus could lose their right to assert their claim due to no fault of their own, unless notice is given to them .... On the other hand, individuals with claims arising after death, largely due to expenses arising out of the administration of the estate, do not encounter similar difficulties. Because [the latter group of creditors] know[s] of the death of the decedent, [the state probate statute] does not require notice and sets forth only a four-month limitation period from the time the claim arose.[46]

The State concedes that administrative processes make it more likely than other creditors to learn of a Medicaid beneficiary's death. But if Medicaid is not providing services to the beneficiary at the time of death, it may not immediately become aware of the death. Applying the deadline for claims arising at or after death risks precluding the State from pursuing legitimate claims when other creditors still can, with no clear policy justification.

Subjecting the State to these costs and risks would be directly at odds with the legislature's decision to give Medicaid estate recovery claims priority over other creditors' claims. The legislature designated Medicaid estate recovery claims as "debts with preference."[47] An estate is required to pay such debts before "all other claims" — excluding estate administration, funeral expenses, and a few other debt categories.[48] Creditors whose claims are based on obligations incurred by the decedent while alive (like doctors, lenders, or business partners) are subject to the deadline for claims arising before death: four months after notice to creditors is published, or three years after death if no notice is published.[49] Medicaid estate recovery claims are also based on obligations incurred by the decedent while alive. Making these claims subject to a different and sometimes more restrictive deadline (four months after death if the decedent had no surviving spouse or qualifying child) than other

creditors' claims would be inconsistent with the legislature's decision to give Medicaid claims priority.

In light of the overall purpose of Medicaid estate recovery claims and the express priority these claims are assigned, it is more logical to classify these claims as arising before death.

C. Decisions From Other States Support The Conclusion That Medicaid Estate Recovery Claims Arise Before Death.

The parties cite opinions from other state appellate courts supporting their respective positions on whether a Medicaid estate recovery claim arises before or after death. These opinions fall into three sets: (1) opinions deciding when claims that become enforceable after death arise for purposes of the probate code; (2) opinions deciding when Medicaid estate recovery claims arise generally; and (3) opinions deciding when Medicaid estate recovery claims arise for purposes of probate filing deadlines. On balance, these decisions support the conclusion that Medicaid estate recovery claims arise before death for purposes of probate claim deadlines.

The first set of decisions establishes that, generally speaking, claims against an estate can arise before death even if they are only enforceable after death. In *In re Estate of Hadaway*, a Minnesota court discussed a claim based on a divorce settlement agreement ***252** that the decedent had entered into during his life, but that was payable only after he died.[50] The court concluded that the claim for payment arose during the decedent's life for the purpose of Minnesota's probate claim deadlines,[51] which are similar to Alaska's.[52] "Simply because the payment was made absolute when decedent died," the court held, "it does not follow that the contractual duty necessarily *arose* at the time of decedent's death. Rather, it is apparent that from the time of the settlement agreement ... decedent was obligated [to fulfill his contract obligations]."[53]

*Estate of Evitt v. Hiatt*also concerned a divorce settlement agreement executed years before death but not enforceable until after death.[54] The Arizona Court of Appeals, applying Arizona's probate code,[55] held "that when a person enters into a contract obligating him to act while living to ensure a payment to the claimant at or after his death, a claim for breach arises before the decedent's death."[56] And *Ader v. Estate of Felger* distinguished the terms "accrue" and "arise" when extending this logic to fraud claims.[57] While "[a] cause of action accrues ... when one party is able to sue another," the *Felger* court explained, "in the context of a nonclaim statute, 'arise' refers to the decedent's act or conduct upon which a claim is based."[58]

These cases support the idea that when a claim arises, for purposes of the probate code's claim filing deadlines, depends on the timing of the events that give rise to the claim, rather than when that claim becomes enforceable.

The second set of decisions addresses the distinct but related issue of when a claim for Medicaid estate recovery arises in general.[59] Most of these decisions support the State's view that Medicaid reimbursement claims arise when caretakers provide services rather than when a recipient passes away.

Most jurisdictions that have addressed the issue have concluded that Medicaid estate recovery claims arise when caretakers provide services to a living Medicaid recipient. In *Estate of Melby v. Lohman*, for example, the Iowa Supreme Court concluded that although the governing statute "mandat[es] the department will refrain from collecting that debt until the death of the recipient," it nonetheless "establishes a debt owed by the recipient of medical services when the services ***253** are provided."[60] Courts reached the same conclusion in Arkansas, Nebraska, and Washington.[61]

Only one state, California, appears to have reached the opposite conclusion outside of the probate claim deadline context. The holding of *Kizer v. Hanna* — that California's Medicaid recovery statute applied to care that took place before the statute went into effect[62] — is irrelevant here. But the *Kizer* court reached that conclusion by reasoning that "[t]he plain language of the statute dictates that the [state agency's] right to reimbursement is against the recipient's *estate*. Consequently, the [state agency's] right to reimbursement arises, if at all, at the time of the recipient's death."[63]

The third set of decisions addresses the precise question at hand: For purposes of probate code filing deadlines, do Medicaid estate recovery claims arise before death, or "at or after" death? These two opinions — *Estate of Hooey v. Mowbray*[64] and *Estate of Tvrz v. Tvrz*[65] — reached opposite conclusions.

In *Estate of Hooey* the Supreme Court of North Dakota held that "[t]he requirement that the [state agency] refrain from pursuing its claim until after the death of the recipient does not define when that claim arose." [66] Rather, the court viewed this requirement as one of several contingencies that must occur before the government may recover Medicaid funds. [67] The court reasoned that "the obligation to repay, if any, arises upon receipt of the benefits, i.e., prior to the decedent's death," whereas the decedent's death and the death of any surviving spouse merely determined when the government's "right to recover ripens." [68]

***254** In *Estate of Tvrz* the Supreme Court of Nebraska adopted the opposite interpretation of Nebraska's Medicaid estate recovery statute. [69] That court deemed it significant that Nebraska's statute "specifically provide[d] that '[n]o debt to the department shall exist' if the recipient is survived by a spouse or by a child who is under the age of 21, blind, or totally and permanently disabled." [70] The court reasoned that "the *existence* of indebtedness on the part of a [Nebraska] recipient's estate depends upon factors which can be determined only after the recipient's death" and that a Nebraska Medicaid estate recovery claim therefore arises only at or after death. [71]

Despite this seemingly even tally, the scale ultimately tips in the State's favor. One year after the *Estate of Tvrz* decision, the Nebraska legislature effectively abrogated it by amending Nebraska's Medicaid estate recovery statute to provide that the debt "arises during the life of the recipient but shall be held in abeyance until death of the recipient." [72] The Nebraska legislature's response to the court's ruling suggests that subjecting Medicaid estate recovery claims to the "before death" probate claim deadline is more consistent with the underlying purpose of the program.

Overall, the decisions from other jurisdictions confirm our analysis of the text and purpose of Alaska's probate and Medicaid statutes. A Medicaid estate recovery claim arises before the death of the decedent. Such a claim is timely if presented to the estate within four months after notice to creditors is first published, or within three years of death if no notice is published.

IV. CONCLUSION

For the reasons above, we REVERSE the superior court's decision in *Estate of Abad* and AFFIRM the superior court's decision in *Estate of Boatner*.

All Citations

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Footnotes

1 AS 13.16.460(a)(1).

2 AS 13.16.460(b)(1).

3 *Smart v. State, Dep't of Health & Soc. Servs.*, 237 P.3d 1010, 1012 (Alaska 2010) (quoting *Hidden Heights Assisted Living, Inc. v. State, Dep't of Health & Soc. Servs.*, 222 P.3d 258, 261 (Alaska 2009)).

4 The Medicaid Act generally excludes an individual's principal residence for purposes of calculating Medicaid eligibility. *West Virginia v. U.S. Dep't of Health & Hum. Servs.*, 289 F.3d 281, 284 & n.3 (4th Cir. 2002) (citing 42 U.S.C. §§ 1382b(a)(1), 1396a(a)(10)(A)(i)(II), 1396a(a)(10)(A)(ii)(V), 1396a(a)(10)(C)(i)(III)).

5 *Id.* at 284.

6 *Id.*

7 *See* Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103–66, § 13612, 107 Stat. 312, 627-28 (codified at 42 U.S.C. § 1396p(b)(1)).

8 *Smart*, 237 P.3d at 1012 (quoting *Hidden Heights*, 222 P.3d at 261).

9 AS 47.07.055(e). Only certain kinds of services, such as "services received while an inpatient in a nursing facility" and "home and community-based services provided through waiver," give rise to a claim for reimbursement by the State. AS 47.07.055(e)(1)-(2).

10 42 U.S.C. § 1396p(b)(2)(A); AS 47.07.055(f).

11 7 Alaska Administrative Code (AAC) 160.210(c).

12 7 AAC 160.240(a)-(b).

13 *Rosauer v. Manos*, 440 P.3d 145, 147 (Alaska 2019).

14 *In re Est. of Rodman*, 498 P.3d 1054, 1062 (Alaska 2021) (quoting *Taylor v. Wells Fargo Home Mortg.*, 301 P.3d 182, 188 (Alaska 2013)).

15 *Am. Marine Corp. v. Sholin*, 295 P.3d 924, 926 (Alaska 2013) (citing *State, Com. Fisheries Entry Comm'n v. Carlson*, 270 P.3d 755, 762 (Alaska 2012)).

16 *McDonnell v. State Farm Mut. Auto. Ins. Co.*, 299 P.3d 715, 721 (Alaska 2013) (citing *Peninsula Mktg. Ass'n v. State*, 817 P.2d 917, 922 (Alaska 1991)).

17 *Id.* (alteration in original) (quoting *Gov't Emps. Ins. Co. v. Graham-Gonzalez*, 107 P.3d 279, 284 (Alaska 2005)).

18 AS 47.07.055(e) ("[A]fter an individual's death, the individual's estate is subject to a claim for reimbursement ....").

19 AS 13.16.460(b).

20 AS 13.16.460(a).

21 "In the absence of a [statutory] definition, we construe statutory terms according to their common meaning[;] [d]ictionaries provide a useful starting point for this exercise." *State v. Recall Dunleavy*, 491 P.3d 343, 359 (Alaska 2021) (alterations in original) (quoting *Alaska Pub. Def. Agency v. Superior Ct.*, 450 P.3d 246, 253 (Alaska 2019)).

22 *Accrue*, BLACK'S LAW DICTIONARY (4th ed. 1968).

23 *Arise*, BLACK'S LAW DICTIONARY (4th ed. 1968).

24 *Id.*

25 *Id.*

26 AS 13.16.460(a)(1) (emphasis added). These qualifiers are used both for claims that arose before death under AS 13.16.460(a)(1) and for claims that arise at or after death under AS 13.16.460(b)(1).

27 *Contingent Claim*, BLACK'S LAW DICTIONARY (4th ed. 1968).

28 AS 13.06.050 (providing definitions for AS 13.06–.36, "[s]ubject to additional definitions contained in AS 13.06–AS 13.36 that are applicable to specific provisions of AS 13.06–AS 13.36").

29 *Id.* (emphasis added).

30 AS 13.06.050(6).

31 *See In re Est. of Baker*, 386 P.3d 1228, 1234 (Alaska 2016) (acknowledging that "members of the Alaska House Judiciary Committee found Richard Wellman's writings on the Uniform Probate Code to be helpful in clarifying the concepts underlying the code," and citing to Richard Wellman's Uniform Probate Code Practice Manual).

32 1 UNIFORM PROBATE CODE PRACTICE MANUAL 343 (Richard V. Wellman, ed., 2d ed. 1977).

33 1 STEIN ON PROBATE, § 6.01(c), at 117 (Robert A. Stein, ed., 3d ed. 1995).

34 *Id*.

35 *Id.*

36 *Id.*

37 *See* AS 13.16.470(a); AS 47.07.055(g).

38 AS 13.06.010(b)(3).

39 AS 13.16.005.

40 AS 13.16.040(a). *But see* AS 12.16.040(a)(1)-(5) (providing exceptions to the general rule).

41 *See* AS 13.16.460(b).

42 *See* AS 13.16.065(a) (establishing order of priority for personal representative of estate, with creditor lowest priority).

43 *See* 42 U.S.C. § 1396p(b)(2); AS 47.07.055(f).

44 *Est. of Melby v. Lohman*, 841 N.W.2d 867, 875-76 (Iowa 2014) ("Our interpretation creating the debt immediately upon provision of assistance rather than at the death of the recipient, and allowing recovery from the corpus of the trust, is consistent with the Medicaid program's goal ...."); *see also Belshe v. Hope*, 33 Cal.App.4th 161, 38 Cal. Rptr. 2d 917, 925 (1995) (explaining that Medicaid estate recovery "furthers the broad purpose of providing for the medical care of [a state's] needy; the greater amount recovered by the state allows the state to have more funds to provide future services"); Jon M. Zieger, *The State Giveth and the State Taketh Away: In Pursuit of a Practical Approach to Medicaid Estate Recovery*, 5 ELDER L.J. 359, 374 (1997) ("The foremost consideration behind estate recovery is the reduction of the overall cost of Medicaid to states by recouping some portion of Medicaid expenditures.").

45 *See* ch. 102, § 1, SLA 1994 (stating that purpose of the act was to, among other things, "bring the state into compliance with federal law with respect to the recovery of Medicaid payments from the estates and trusts of individuals under certain circumstances"); Sen. Steve Frank, Sponsor Statement for S.B. 366, 18th Leg. 2d Sess. (Mar. 26, 1994) ("In large part, the statutory changes proposed in this bill relating to ... estate recoveries by Medicaid, and Medicaid-qualifying trusts are required by the federal Omnibus Budget Reconciliation Act of 1993 ... , and DHSS will face a penalty — loss of federal financial Medicaid participation — if legislation is not adopted by July 1, 1994."); 42 U.S.C. § 1396p(b)(1)(B) ("In the case of an individual who was 55 years

of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate ....").

46 *In re Est. of Hadaway*, 668 N.W.2d 920, 924 (Minn. App. 2003).

47 AS 47.07.055(g) ("For purposes of AS 13.16.470, the claims authorized under this section are debts with preference under the laws of the state.").

48 AS 13.16.470(a).

49 AS 13.16.460(a)(1)-(2).

50 668 N.W.2d at 920-21.

51 *Id.* at 923.

52 Minnesota Statutes §§ 524.3–803(a) and (b)(2), like AS 13.16.460(a) and (b)(2), require creditors whose claims against an estate "arose before the death of the decedent" to file within four months after a notice to creditors and claims that "arise at or after the death of the decedent" to be filed within four months after they arise.

53 *In re Est. of Hadaway,* 668 N.W.2d at 923 (emphasis in original).

54 245 Ariz. 352, 429 P.3d 1146, 1147-48 (Ariz. App. 2018).

55 Ariz. Rev. Stat. Ann. § 14-3803 likewise assigns a different filing deadline to creditors whose claims arose "before the death of the decedent" than to those whose claims "arise at or after the death of the decedent."

56 *Est. of Evitt*, 429 P.3d at 1147; *see also Spohr v. Berryman*, 589 So. 2d 225, 227-28 (Fla. 1991) (holding that a claim against the decedent's estate based on a divorce agreement "arose before the death of the decedent" because the claim "was based upon an agreement which was made many years before [the decedent's] death").

57 240 Ariz. 32, 375 P.3d 97, 103-04 (Ariz. App. 2016).

58 *Id*. at 104 (quoting *Gust, Rosenfeld & Henderson v. Prudential Ins. Co. of Am.,* 182 Ariz. 586, 898 P.2d 964, 966 (1995)).

59 Two cases the estates cite — *In re Est. of Baker*, 627 S.W.3d 523 (Tex. App. 2021) and *In re Est. of Hutchinson*, 577 P.2d 1074 (Alaska 1978) — are inapposite. *In re Est. of Baker* distinguishes two kinds of claims: (1) an equitable right of reimbursement arising from the dissolution of marriage and (2) a debt to one's spouse. *See* 627 S.W.3d at 532. It does not discuss "reimbursement" in the Medicaid recovery context. *Id.* at 527 ("The right of reimbursement is not an interest in property or an enforceable debt, per se, but an equitable right which arises upon dissolution of the marriage."). *In re Est. of Hutchinson* examines whether family allowances qualify as claims against an estate. 577 P.2d at 1074-76. It is unclear that there is any connection to the matter at hand, other than a mere reference to the definition of "claims" and the claim priority statute, AS 13.16.470(a). *Id.*

60 841 N.W.2d 867, 877 (Iowa 2014). Abad's estate attempts to distinguish Iowa's Medicaid recovery statute from Alaska's, pointing out that the Iowa statute conceptualizes Medicaid recovery as debt collection rather than reimbursement. *Compare* Iowa Code § 249A.53(2) (formerly Iowa Code § 249A.5(2)) ("The provision of medical assistance to an individual ... creates a debt due the department from the individual's estate ...."), *with* AS 47.07.055(e) ("[T]he individual's estate is subject to a claim for reimbursement for medical assistance

payments ....”). But the slightly different language used does not seem to indicate a different underlying legislative intent. The two statutes arise from the same federal mandate to implement state Medicaid recovery programs, and therefore share the same purpose. *See* *Est. of Melby*, 841 N.W.2d at 875-76 (“Our interpretation creating the debt immediately upon provision of assistance rather than at the death of the recipient, and allowing recovery from the corpus of the trust, is consistent with the Medicaid program's goal of recovering from those with an ability to pay so as to make future funds available for those having the most need.”).

61 *See, e.g.*, *Est. of Wood v. Ark. Dep't of Hum. Servs.*, 319 Ark. 697, 894 S.W.2d 573, 576 (1995) (explaining that the relationship created by Arkansas's estate recovery statute “was as if [the recipient] had a loan from [the department] to be repaid from the assets of her estate”); *Est. of Reimers v. Neb. Dep't of Health & Hum. Servs.*, 16 Neb.App. 610, 746 N.W.2d 724, 728 (2008) (“While the debt arising under [the estate recovery] statute accrues during the recipient's lifetime, it is held in abeyance for payment until the recipient's death.”); *In re Est. of Burns*, 131 Wash.2d 104, 928 P.2d 1094, 1099 (1997) (“The precipitating event [of a Medicaid reimbursement claim] is ... the receipt of the benefits giving rise to the contingent indebtedness, and not the creation of the decedent's estate.”).

62 48 Cal.3d 1, 255 Cal.Rptr. 412, 767 P.2d 679, 686 (1989).

63 *Id*., 255 Cal.Rptr. 412, 767 P.2d at 683 (emphasis in original). Boatner's estate cites to another California decision, *Maxwell-Jolly v. Martin*, for the proposition that the reimbursement right is strictly a statutory right to recover from a decedent recipient's estate and is not based on any promise or agreement to repay by the still-living recipient. 198 Cal.App.4th 347, 129 Cal. Rptr. 3d 278 (2011). The *Maxwell-Jolly* court relied on the California Supreme Court's reasoning in *Kizer* in reaching that conclusion. *Id.* at 288. But the majority of jurisdictions have taken the opposite approach, and we find the reasoning of those courts more persuasive.

64 521 N.W.2d 85 (N.D. 1994).

65 260 Neb. 991, 620 N.W.2d 757 (2001), *superseded by statute*, 2001 Neb. Laws, L.B. 257, § 1, Neb. Rev. Stat. § 68–1036.02(2) (2001), *as recognized in Est. of Cushing v. Neb. Dep't of Health & Hum. Servs.*, 283 Neb. 571, 810 N.W.2d 741, 745 (2012) (“*In re Estate of Tvrz* is no longer authoritative on when DHHS' claim arises.”).

66 521 N.W.2d at 86 (citations omitted).

67 *See id*. at 86-87 (quoting *Dep't of Pub. Welfare v. Anderson*, 377 Mass. 23, 384 N.E.2d 628, 633-34 (1979)).

68 *Id*. at 87 (quoting *Anderson*, 384 N.E.2d at 633-34).

69 620 N.W.2d at 762-63.

70 *Id*. (quoting former Neb. Rev. Stat. § 68–1036.02(2)).

71 *Id*. at 763 (emphasis in original).

72 *Est. of Cushing v. Neb. Dep't of Health & Hum. Servs.*, 810 N.W.2d at 745-46 (quoting Neb. Rev. Stat. § 68–919) (holding, in light of statutory change, that Medicaid estate recovery claim arose before beneficiary's death).

998 N.W.2d 308
Court of Appeals of Minnesota.

IN RE the ESTATE OF: Joanne Mary ECKLUND, Decedent.

A23-0210
|
Filed November 20, 2023

Synopsis

Background: County asserted claim against estate of decedent, seeking to recover $66,052.62 as portion of capitation payments attributable to long-term-care services made through state medical-assistance program. The District Court, Hennepin County, Michael K. Browne, J., granted county partial summary judgment for $8,806.84 and denied remainder of county's claim. County appealed, and Commissioner of state Department of Human Services intervened.

Holdings: The Court of Appeals, Bjorkman, J., held that:

county was not entitled, under estate-recovery statute for medical-assistance program, to recover from estate full amount of capitation payments rendered to managed-care organization (MCO) during decedent's life as part of medical assistance program, and

county was entitled, under estate-recovery statute, to recover $8,806.84 from estate, as costs of enumerated long-term-care services actually provided to decedent during life based on participation in program.

Affirmed.

Procedural Posture(s): On Appeal; Motion for Summary Judgment.

***310** *Syllabus by the Court*

The unambiguous language of Minn. Stat. § 256B.15, subd. 2(a) (2022), limits a claim to recover from the estate of a person who received medical assistance to amounts paid for the cost of long-term-care services actually provided to that person.

Hennepin County District Court, File No. 27-PA-PR-21-1424

Attorneys and Law Firms

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Considered and decided by Connolly, Presiding Judge; Bjorkman, Judge; and Klaphake, Judge. [*]

OPINION

BJORKMAN, Judge

Appellant-county challenges the district court's partial denial of its claim to recover from the estate of a person who received medical assistance for long-term-care services. Appellant argues that the district court erred by interpreting Minn. Stat. § 256B.15, subd. 2(a), to limit recovery to amounts paid for services provided to decedent, asserting that the plain language of the statute permits recovery of the amount of "capitation" payments it made to decedent's managed-care organization (MCO) to cover the cost of decedent's long-term-care services. Intervenor-commissioner supports the county's appeal and argues that federal law requires recovery of capitation payments. We affirm.

FACTS

Decedent Joanne Ecklund (decedent) was enrolled in Minnesota's medical-assistance program and received benefits through her MCO, Medica. During decedent's ***311** lifetime, the medical-assistance program made capitation payments, which are similar to insurance premiums, to Medica. Following her death in August 2021, appellant Hennepin County Human Services (the county) [1] asserted a claim against the estate under Minn. Stat. § 256B.15 (2022), seeking to recover $66,052.62 as the portion of

capitation payments attributable to long-term-care services. The estate's personal representative, respondent Jerry R. Ecklund (Ecklund), opposed the claim. Ecklund argued, in relevant part, that the scope of an estate-recovery claim is limited under Minn. Stat. § 256B.15, subd. 2(a), and does not include capitation payments.

The county and Ecklund filed opposing motions for summary judgment based on stipulated facts. The district court concluded that the county is entitled to recover but that the plain language of Minn. Stat. § 256B.15, subd. 2(a), does not permit recovery of capitation payments made to Medica; it permits recovery of only the amount that Medica paid to providers for services actually provided to decedent, which undisputedly is $8,806.84. Accordingly, the court granted the county partial summary judgment for that amount, denying the remainder of the county's claim.

The county appealed and the Commissioner of Human Services (commissioner) intervened. [2]

ISSUE

Does Minn. Stat. § 256B.15, subd. 2(a), limit an estate-recovery claim to amounts paid for long-term-care services actually provided to the decedent?

ANALYSIS

Summary judgment is proper if the moving party shows that "there is no genuine issue as to any material fact and the movant is entitled to judgment as a matter of law." Minn. R. Civ. P. 56.01. Where, as here, a district court grants summary judgment "based on the application of a statute to undisputed facts, the result is a legal conclusion," which we review de novo. *In re Est. of Handy*, 672 N.W.2d 214, 217 (Minn. App. 2003), *rev. denied* (Minn. Feb. 17, 2004).

When interpreting statutes, our role is to identify and effectuate the legislature's intent. Minn. Stat. § 645.16 (2022); *Pfoser v. Harpstead*, 953 N.W.2d 507, 516 (Minn. 2021). We begin by examining the statute's language to determine if it is ambiguous, meaning it "is susceptible to more than one reasonable interpretation." *A.A.A. v. Minn. Dep't of Hum. Servs.*, 832 N.W.2d 816, 819 (Minn. 2013). In determining whether a statute is ambiguous, we consider the whole statute, not just disputed language. *Id.* And we read the statute as it is, without adding language. *Firefighters Union Loc. 4725 v. City of Brainerd*, 934 N.W.2d 101, 109 (Minn. 2019). We construe undefined words and phrases according to their common usage and may consider dictionary definitions. Minn. Stat. § 645.08(1) (2022); *Pfoser*, 953 N.W.2d at 517. But a term's meaning also depends on its context. *Getz v. Peace*, 934 N.W.2d 347, 355 (Minn. 2019). If we discern the legislature's intent from the statute's plain language, we are constrained to apply that unambiguous meaning. *In re Schmalz*, 945 N.W.2d 46, 50 (Minn. 2020).

***312** Minnesota provides "medical assistance" to people whose financial resources are insufficient to meet the cost of necessary healthcare services. Minn. Stat. § 256B.01 (2022); *see also Pfoser*, 953 N.W.2d at 514 (explaining that medical assistance is Minnesota's implementation of Medicaid). Following the death of a medical-assistance recipient, Minn. Stat. § 256B.15 provides for recovery from their estate. [3] This estate-recovery statute begins by stating its underlying policy —that those who receive medical assistance "use their own assets to pay their share of the cost of their care." Minn. Stat. § 256B.15, subd. 1(a). To effectuate this policy, the statute requires that, upon the death of a person who received medical assistance, "the amount paid for medical assistance ... shall be filed as a claim against the estate of the person." *Id.*, subd. 1a(a). Such claims "shall be filed" only if medical assistance was "rendered for" the person under certain circumstances, including if "the person was 55 years of age or older and received medical assistance services that consisted of nursing facility services, home and community-based services, or related hospital and prescription drug benefits." *Id.*, subd. 1a(e)(3). And the legislature specified that estate-recovery claims "shall include only" specified amounts, including "the amount of medical assistance rendered to recipients 55 years of age or older that consisted of nursing facility services, home and community-based services, and related hospital and prescription drug services." *Id.*, subd. 2(a). It is the meaning of this claim-limitation provision that is at issue here.

The parties contend this provision is unambiguous but offer competing interpretations. The county and the commissioner argue that the provision unambiguously means that an estate-recovery claim includes the amount of capitation payments rendered to an MCO on behalf of a medical-assistance recipient to pay for the cost of the enumerated long-term-care services. They urge us to focus on the phrase "medical assistance," which is defined as "payment of part or all of the cost of the care and services identified [as covered services] in section 256B.0625, for eligible individuals whose

income and resources are insufficient to meet all of this cost." Minn. Stat. § 256B.02, subd. 8 (2022); *see* Minn. Stat. § 256B.0625 (2022) (listing covered services). They assert that this definition includes capitation payments, advancing similar but distinct justifications. The county emphasizes the "payment" part of the definition, arguing that, for people like decedent who receive medical assistance through an MCO, the state renders "payment" for covered services by making capitation payments to the MCO. The commissioner emphasizes the "cost" part of the definition, arguing that capitation payments are "the cost of [covered] services." We reject the county and the commissioner's interpretation for two reasons.

First, the term "capitation" is conspicuously absent not only from the claim-limitation provision at issue but from the estate-recovery statute as a whole. *See* ***313** *generally* Minn. Stat. § 256B.15. By contrast, the legislature uses the term repeatedly in other medical-assistance statutes. For example, it mandates that the commissioner develop "capitation rates" and details standards for doing so. Minn. Stat. § 256B.6928, subd. 3 (2022). It requires that "capitation rates" or "capitation payments" be adjusted to account for various services being included or excluded from covered services. Minn. Stat. § 256B.0625, subds. 5m(d), 17a(b), 52(a). And it defines the term "prepaid health plan" in terms of receipt of "a capitation payment." Minn. Stat. § 256B.02, subd. 13 (2022). In short, the legislature knows how to include capitation payments in a statute but chose not to do so in the estate-recovery statute. Under these circumstances, the "black-letter rule" prohibiting us from adding language to a statute "has special force." *Firefighters Union*, 934 N.W.2d at 109.

Second, the claim-limitation provision's use of the phrase "medical assistance" does not bridge this gap. As we noted above, "medical assistance" refers to payment of the cost of covered services. Minn. Stat. § 256B.02, subd. 8. The term "capitation" refers to a similar sounding concept—"a method of payment for health services that involves a monthly per person rate paid on a prospective basis to a health plan." Minn. R. 9500.1451, subp. 4 (2021). But the concepts are distinct.

The state makes capitation payments to an MCO based on rates that anticipate the cost of covered services by considering recent years' price and utilization data from the "medical assistance population." Minn. Stat. § 256B.6928, subd. 3(a)(1)-(2), (b). The rate also includes a "nonbenefit component" to cover the MCO's operational expenses. *Id.*, subd. 3(a)(3). In exchange for capitation payments, the MCO takes on the "financial risk" of providing "medical assistance services." Minn. Stat. § 256B.02, subd. 13; *see Getz*, 934 N.W.2d at 356 (describing this "exchange"). The MCO manages this risk by negotiating with healthcare providers to secure discounts for the cost of covered services that they provide to medical-assistance recipients. *See Getz*, 934 N.W.2d at 356 & n.9. As a result, depending on the extent of covered services that a recipient actually receives and the extent of discounts that the MCO negotiates with providers, the amount the MCO receives in capitation for the recipient may be more or less than the amount it pays for covered services that the recipient actually receives. [4]

In short, a capitation payment enables and even requires an MCO to pay the cost of covered services, but it is not itself the cost of covered services or payment of that cost. As such, it is not medical assistance for purposes of recovery from a recipient's estate. Accordingly, the county and the commissioner's interpretation of the limitation provision as allowing recovery of capitation payments is unreasonable.

Ecklund advances a different interpretation of the claim-limitation provision—that an estate-recovery claim is limited to the amount paid for the cost of the enumerated long-term-care services that were actually provided to the medical-assistance recipient. He contends the phrase "rendered to recipients" requires this interpretation. We agree.

The term "render" means to "give" or "provide." *The American Heritage Dictionary of the English Language* 1487 (5th ***314** ed. 2011). The phrase "rendered to recipients" modifies the phrase "medical assistance" because it immediately follows that phrase. *In re Est. of Butler*, 803 N.W.2d 393, 397 (Minn. 2011) (stating that "a qualifying phrase ordinarily modifies only the noun or phrase it immediately follows"). The two phrases together refer to *payment of the cost of covered services provided to recipients*. This phrase, in turn, could mean that (1) the referenced payment was provided to recipients directly, (2) the referenced payment was provided to recipients indirectly, or (3) the referenced services were provided to recipients. Only one of these three interpretations is reasonable.

Payment of the cost of covered services provided to recipients cannot mean that the payment was provided directly to the person receiving the covered services because medical-assistance payments are not made directly to the recipient;

they are made "to the vendor." Minn. Stat. § 256B.03, subd. 1 (2022). Nor are we persuaded that the phrase refers to indirect payment on the recipient's behalf because it would mean that medical assistance, which encompasses concepts of payment and services, is "rendered to" a recipient even if neither payment nor services were actually provided to the recipient. This means that the only reasonable interpretation of the phrase "medical assistance rendered to recipients" refers to the services part of "medical assistance," meaning covered services that were provided to the recipient.

Consideration of the rest of the estate-recovery statute convinces us that this services-oriented reading of Minn. Stat. § 256B.15, subd. 2(a), is the only reasonable one. *See Getz*, 934 N.W.2d at 355 (requiring consideration of statutory context in plain-language analysis). First, the latter portion of that provision, referring to specific long-term-care services, makes more sense when "medical assistance" refers to services. It is undisputed that actuarial analysis can define the portion of capitation payments attributable to anticipated use of particular services; as a result, interpreting the provision to refer to "medical assistance [payments] ... that consisted of" the listed long-term-care services sounds odd but may make sense. But interpreting the provision to refer instead to services actually provided to a recipient—specifically, "medical assistance [services] ... that consisted of" the listed long-term-care services—affords a more natural reading and a clearer and more concrete rubric. *See Krueger v. Zeman Constr. Co.*, 781 N.W.2d 858, 861 (Minn. 2010) (stating that courts construe statutory language words and phrases "according to their most natural and obvious usage" (quotation omitted)).

Moreover, the estate-recovery statute's claim-filing requirement only applies "if medical assistance was rendered for ... [a] person [who] was 55 years of age or older and *received medical assistance services* that consisted of [long-term-care services]." Minn. Stat. § 256B.15, subd. 1a(e)(3) (emphasis added). This is consistent with the legislature's articulated policy that the estate-recovery statute does not call for maximizing recovery; it calls for equitable contribution for services received by collecting from medical-assistance recipients' estate "*their share* of the cost of their care." Minn. Stat. § 256B.15, subd. 1(a) (emphasis added); *see In re Est. of Turner*, 391 N.W.2d 767, 770 (Minn. 1986) (stating that estate-recovery statute creates a "system whereby money paid to qualified individuals for health care purposes may be recovered and reused to help other similarly situated persons").

In sum, based on our careful consideration of the estate-recovery statute as ***315** a whole, we conclude that the only reasonable interpretation of Minn. Stat. § 256B.15, subd. 2(a), is that an estate-recovery claim is limited to the amount paid for the cost of covered services that were actually provided to the person receiving medical assistance. The claim does not include capitation payments. In light of this conclusion, we decline to address the parties' arguments regarding extrinsic factors like agency guidance, parallel federal provisions, legislative history, and the consequences of this interpretation.[5] *See Schmalz*, 945 N.W.2d at 50 (stating that courts "will not disregard a statute's clear language to pursue the spirit of the law" (quotation omitted)).

DECISION

Because Minn. Stat. § 256B.15, subd. 2(a), limits an estate-recovery claim to the amount paid for long-term-care services actually provided to a medical-assistance recipient, the district court did not err by applying that unambiguous meaning and denying the portion of the county's claim that exceeds that amount.

Affirmed.

All Citations

998 N.W.2d 308

Footnotes

* Retired judge of the Minnesota Court of Appeals, serving by appointment pursuant to Minn. Const. art. VI, § 10.

1 County human-services agencies administer medical assistance in their respective counties under the supervision of the Minnesota Department of Human Services. Minn. Stat. § 256B.05, subd. 1 (2022).

2 The commissioner may "intervene as a party in any proceeding involving recovery of medical assistance." Minn. Stat. § 256B.15, subd. 9.

3 The commissioner argues that federal Medicaid law mandates recovery of capitation payments, citing the requirement that "[a] State plan for medical assistance" provide for the state to seek recovery from certain recipients' estates. 42 U.S.C. §§ 1396a(a)(18), 1396p(b)(1)(B)(i) (2018). The Minnesota legislature plainly adopted Minn. Stat. § 256B.15 to comply with this requirement. *See* Minn. Stat. § 256B.22 (2022) (stating that medical-assistance statutes "are intended to comply with" federal Medicaid law). But the commissioner acknowledges that this appeal turns on the interpretation of Minn. Stat. § 256B.15 and, therefore, parallel provisions in federal law are relevant here only if the state statute is ambiguous. *See Schmalz*, 945 N.W.2d at 50.

4 For example, in this case Medica received $66,052.62 in capitation payments for decedent's long-term-care services but paid only $8,806.84 to providers for services that decedent received.

5 All three parties advance arguments as to the consequences of the competing statutory interpretations. While we decline to substantively address those arguments, we note that the commissioner's concern that our interpretation of Minn. Stat. § 256B.15, subd. 2(a), places Minnesota out of compliance with federal law is, as she acknowledges, a matter between the state and the federal government, not the state and Ecklund. And if the legislature shares the commissioner's concerns, it has the power to amend the statute accordingly. *See State v. Khalil*, 956 N.W.2d 627, 642 (Minn. 2021) (stating that, if legislature intends something other than court's plain-language interpretation, it may reexamine and amend the statute); *see also Getz*, 934 N.W.2d at 357 (stating if a statute "needs revision in order to make it embody a more sound public policy, the Legislature, not the judiciary, must be the reviser" (quotation omitted)).

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Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of New Jersey, Appellate Division.

H.L., Petitioner-Appellant,
v.
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES and Monmouth County Division of Social Services, Respondents-Respondents.

DOCKET NO. A-2052-21
|
Submitted October 23, 2023
|
Decided November 16, 2023

On appeal from the New Jersey Department of Human Services, Division of Medical Assistance and Health Services.

Attorneys and Law Firms

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Matthew J. Platkin, Attorney General, attorney for respondent New Jersey Department of Human Services, Division of Medical Assistance and Health Services (Melissa H. Raksa, Assistant Attorney General, of counsel; Francis Xavier Baker, Deputy Attorney General, on the brief).

Patrick James Boyle, attorney for respondent Monmouth County Division of Social Services, on the statement in lieu of brief.

Before Judges Mawla and Marczyk.

Opinion

PER CURIAM

***1** H.L. appeals from the January 25, 2022 final agency decision of the Division of Medical Assistance and Health Services ("Division") upholding the transfer penalty on H.L.'s receipt of Medicaid benefits. In doing so, the Assistant Commissioner adopted the decision of the Administrative Law Judge ("ALJ"). We affirm.

I.

H.L. was institutionalized at a long-term skilled nursing facility in June 2020. In September 2020, H.L. applied for managed long-term services and supports ("MLTSS") Medicaid benefits to the Monmouth County Division of Social Services ("MCDSS"). H.L. included a letter from her son P.L. dated July 15, 2020, stating H.L. lived with P.L. in Connecticut from January 1996, through January 2020. She continued to live in his home when P.L. moved to Georgia in January 2020, until June 2020, when she went to a nursing home.

On December 9, 2020, the MCDSS sent a letter to H.L.'s Designated Authorized Representative for Medicaid purposes, requesting multiple verifications to determine Medicaid eligibility. On December 24, 2020, the MCDSS received another letter from P.L. dated July 21, 2020,[1] explaining H.L.'s spending habits. He stated H.L. lived in his house and "paid rent, utilities, transportation, ... total[ing] $875[ ]," and that "she spent the rest as her personal allowance which was often too little so [he] help[ed] her out."

By correspondence dated January 4, 2021, the MCDSS sent a request for additional information, asking H.L. to verify sixty transactions[2] made during the five-year look-back period, from September 2015 to September 2020. Specifically, the letter stated:

> AS THERE COULD POSSIBLY BE A GIFTING PENALTY INVOLVED DUE TO MONIES GIVEN TO [H.L.]'S SON, A FULL LOOK BACK AT HER RESOURCES WAS PERFORMED. PLEASE SEE THE ATTACHED LARGE TRANSACTION LIST. PLEASE VERIFY EACH TRANSACTION. FOR WHICHEVER TRANSACTIONS ARE EXPLAINED BY THE 7/21/20 UNSIGNED LETTER FROM [P.L.], PLEASE PROVIDE A COPY OF ANY RENTAL AGREEMENTS SIGNED BY [H.L.] AND HER SON, [P.L.] ANY AGREEMENTS

> SHOULD HAVE BEEN WRITTEN UP [AND] SIGNED AT THE TIME THEY BEGAN LIVING TOGETHER. PLEASE ALSO PROVIDE ANY CHECKS/BILLS/ RECEIPTS TO VERIFY HER LIVING EXPENSES, ETC. PLEASE MAKE SURE ANY WRITTEN ATTESTATIONS ARE SIGNED BY THE ATTESTOR.

On January 14, 2021, H.L. submitted a certification stating she lived with her son since 1996. H.L. further stated how she would withdraw one large amount from her bank account each month for all of her daily expenses and that she gave $875 to P.L. "for rent, and other miscellaneous expenditures for [her] daily living." Additionally, H.L. attested she "did not give any of [her] funds to [her] family as a gift and used [her] minimal income for only [her] expenses monthly." The MCDSS advised in their January 19, 2021 letter that a 162-day penalty would be imposed related to transfers totaling $58,000 for less than fair market value during the five-year look-back period.

***2** On February 9, 2021, the MCDSS revised the penalty to 139 days based on transfers totaling $49,875 to P.L. during the look-back period. The revision was a result of both H.L. and P.L.'s certifications to the MCDSS that $875 of the withdrawn funds each month related to rental payments from H.L. to P.L. Because there was still no verification of a rental or expense agreement, the MCDSS found the reduced $875 transactions fell under "love and affection." The MCDSS relied on N.J.A.C. 10:71-4.10(b)(6)(i) for the proposition that transfers made for "love and affection" are not considered a transfer for fair market value. The MCDSS reduced each original penalty transaction to the attested rental amount of $875. [3] The MCDSS determined the excess amount of each $875 withdrawal was used for H.L.'s living expenses, and this excess amount was not included in the revised penalty total. Thus, for each transaction, any amount in excess of $875 was accepted by MCDSS as H.L.'s living expenses and was not included in H.L.'s total penalty.

In the same February 9, 2021 letter, the MCDSS approved H.L.'s Medicaid application effective August 1, 2020. However, because of the imposition of the 139-day penalty, Medicaid would not cover H.L.'s room and board at her nursing facility from August 1, 2020, to December 18, 2020. H.L. requested an administrative hearing, and the matter was transmitted to the Office of Administrative Law.

On October 19, 2021, a hearing was held before an ALJ. An MCDSS worker testified on its behalf. She explained the MCDSS's application process, how she reviewed H.L.'s application for benefits, the rationale behind reducing the penalty based on the attestations provided by H.L. and P.L., and the reasoning supporting the 139-day transfer penalty based on H.L.'s failure to produce a rental agreement or any form of receipts, bills, or invoices substantiating her living expenses.

H.L. submitted a certification from P.L. dated October 18, 2021, which stated that "nearly all" of H.L.'s income went towards her share of the household expenses. P.L. certified he did not have any rental agreement with H.L. because "we do not charge family members rent but family members, sharing a home, all contribute towards their share of the household expenses." Neither H.L. nor P.L. testified at the hearing.

On November 4, 2021, the ALJ issued an initial decision affirming the 139-day transfer penalty. The ALJ found H.L.: lived with her son for approximately twenty-five years; had a fixed monthly income that never exceeded $1,037.24; gave her son $875 monthly; and had no rental agreement or expense agreement with P.L. during the five-year look-back period. The ALJ noted the inconsistencies between H.L.'s January 14, 2021 certification, wherein she stated she paid rent and other expenses, and P.L.'s representation in his July 21, 2020 letter that H.L. paid $875 for rent, compared with P.L.'s subsequent October 18, 2021 certification, which stated H.L. paid no rent, but instead paid for her daily living expenses. Regarding a lack of documentation, the ALJ noted H.L. provided no rental agreement, nor any receipts or bills to corroborate the monthly expenses H.L. purportedly paid.

Ultimately, the ALJ found H.L. failed to meet her burden of showing P.L. was entitled to compensation related to household expenses or rent during the look-back period. The ALJ also concluded H.L. failed to rebut the presumption that $49,875 was transferred from her account to establish Medicaid eligibility and was therefore subject to a 139-day transfer penalty. H.L. filed exceptions to the initial decision.

On January 25, 2022, in a final agency decision, the Division adopted the ALJ's initial finding that H.L. failed to rebut the presumption that these transfers were done for the purposes of qualifying for Medicaid under N.J.A.C. 10:71-4.10(j). The

Division agreed H.L. failed to demonstrate through credible documentary evidence the purpose of the specific transfers at issue. Specifically, both H.L. and P.L. did not provide any rental agreement, receipts, bills, invoices, or other documentation showing the specific household expenses that H.L. allegedly helped pay or how it was determined what portion of the household expenses she would pay.

***3** The Division also noted the contradictions in H.L.'s and P.L.'s statements. The Division stated, "both [H.L.] and P.L.'s previous statements to [the] MCDSS advised that these $875 payments to P.L. were for rent, which P.L. now states is not the case." Additionally, the Division noted the transfers directly to P.L.'s account, particularly those occurring in June and August 2020, appeared to have been made after H.L. moved out of P.L.'s house and into a nursing home. H.L. would not have been living with P.L. during the time these transactions occurred, and H.L. did not provide an explanation for the transfers.

Ultimately, the Division adopted the findings of the ALJ. It held that H.L. had failed to meet her burden to show the transfers at issue were solely for a purpose other than to qualify for Medicaid.

II.

On appeal, H.L. argues the final agency decision adopting the ALJ's imposition of a transfer penalty was arbitrary, capricious, and unreasonable. She contends the term "rent" was ambiguous as utilized in both P.L.'s July 21, 2020 letter and H.L.'s January 14, 2021 certification. H.L. claims both of those letters are unclear on which portion of the $875 was used for rent, and what was meant by the term "rent." She argues her son's October 18, 2021 certification made clear there was no formal rental agreement and that H.L. simply contributed toward her share of household expenses. H.L. further asserts the Division improperly disregarded P.L.'s October 18, 2021 certification.

Our role in reviewing the decision of an administrative agency is limited. In re Stallworth, 208 N.J. 182, 194 (2011) (citing Henry v. Rahway State Prison, 81 N.J. 571, 579 (1980)). We accord a strong presumption of reasonableness to an agency's exercise of its statutorily delegated responsibility and defer to its fact-finding. City of Newark v. Nat. Res. Council in Dep't of Env't Prot., 82 N.J. 530, 539 (1980); Utley v. Bd. of Rev., Dep't of Lab., 194 N.J. 534, 551 (2008). We will not upset the determination of an administrative agency absent a showing that it was arbitrary, capricious, or unreasonable; that it lacked fair support in the evidence; or that it violated legislative policies. Lavezzi v. State, 219 N.J. 163, 171 (2014); Campbell v. Dep't of Civ. Serv., 39 N.J. 556, 562 (1963). "A reviewing court 'may not substitute its own judgment for the agency's, even though the court might have reached a different result.' " In re Stallworth, 208 N.J. at 194 (quoting In re Carter, 191 N.J. 474, 483 (2007)).

In determining whether agency action is arbitrary, capricious, or unreasonable, a reviewing court must examine:

> (1) whether the agency's action violates express or implied legislative policies, that is, did the agency follow the law; (2) whether the record contains substantial evidence to support the findings on which the agency based its action; and (3) whether in applying the legislative policies to the facts, the agency clearly erred in reaching a conclusion that could not reasonably have been made on a showing of the relevant factors.
>
> [Ibid. (quoting In re Carter, 191 N.J. at 482-83).]

"The party challenging the agency action has the burden to show that the administrative determination is arbitrary, capricious, or unreasonable." In re Renewal Application of TEAM Acad. Charter Sch., 247 N.J. 46, 73-74 (2021) (citing Lavezzi, 219 N.J. at 171).

"Medicaid is a federally-created, state-implemented program that provides 'medical assistance to the poor at the expense of the public.' " In re Est. of Brown, 448 N.J. Super. 252, 256 (App. Div. 2017) (quoting Est. of DeMartino v. Div. of Med. Assistance & Health Servs., 373 N.J. Super. 210, 217 (App. Div. 2004)); see also 42 U.S.C. § 1396-1. To receive federal funding, the State must comply with all federal statutes and regulations. Harris v. McRae, 448 U.S. 297, 301 (1980); see also 42 U.S.C. § 1396a(a)-(b). The State must adopt " 'reasonable standards ... for determining eligibility for ... medical assistance ... [that are] consistent with the objectives' of the Medicaid program[,]" Mistrick v. Div. of Med. Assistance & Health Servs., 154 N.J. 158, 166 (1998) (first alteration in original) (quoting L.M. v. Div. of Med. Assistance & Health Servs., 140 N.J. 480, 484 (1995)), and "provide for taking into account only such income and resources as are ... available to the applicant." N.M. v. Div. of Med. Assistance & Health Servs., 405 N.J. Super. 353, 359, (App. Div. 2009); see also 42 U.S.C. § 1396a(a)(17)(A)-(B).

***4** New Jersey participates in the federal Medicaid program pursuant to the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 to -19.5. Eligibility for Medicaid in New Jersey is governed by regulations adopted in accordance with the authority granted by N.J.S.A. 30:4D-7 to the Commissioner of the Department of Human Services (DHS). The Division is the agency within the DHS that administers the Medicaid program. N.J.S.A. 30:4D-5, -7; N.J.A.C. 10:49-1.1. Accordingly, the Division is responsible for protecting the interests of the New Jersey Medicaid program and its beneficiaries. N.J.A.C. 10:49-11.1(b).

H.L. applied for institutional-level Medicaid benefits while she was residing in a skilled nursing home. The Division provides such benefits pursuant to the Medicaid Only program, N.J.A.C. 10:71-1.1 to -9.5. Among other eligibility requirements, an individual seeking such benefits must have financial eligibility as determined by the regulations and procedures. See N.J.A.C. 10:71-1.2(a). The local county welfare agencies evaluate eligibility, which in this case is the MCDSS. N.J.S.A. 30:4D-7a; N.J.A.C. 10:71-1.5, -2.2(c). Through those county agencies, the Division serves as a "gatekeeper to prevent individuals from using Medicaid to avoid payment of their fair share for long-term care." W.T. v. Div. of Med. Assistance & Health Servs., 391 N.J. Super. 25, 37 (App. Div. 2007).

The transfer of an asset for less than fair market value during the look-back period raises a rebuttable presumption that the asset was transferred for the purpose of establishing Medicaid eligibility. H.K. v. Dep't of Hum. Servs., 184 N.J. 367, 380 (2005) (citing N.J.A.C. 10:71-4.10(j)); see also 42 U.S.C. § 1396p(c)(1). To rebut that presumption, the applicant must present "convincing evidence that the assets were transferred exclusively (that is, solely) for some other purpose." N.J.A.C. 10:71-4.10(j). The presumption "shall be considered successfully rebutted only if the applicant demonstrates that the asset was transferred exclusively for some other purpose." N.J.A.C. 10:71-4.10(l)(1). "If the applicant had some other purpose for transferring the asset, but establishing Medicaid eligibility appears to have been a factor in his or her decision to transfer, the presumption shall not be considered successfully rebutted." N.J.A.C. 10:71-4.10(l)(2). The regulations are clear that the applicant bears the burden of proof to rebut the presumption by presenting credible documentary evidence of the fair market value of the transferred assets. N.J.A.C. 10:71-4.10(j). The regulation allows the applicant to rebut the presumption that an unauthorized Medicaid transfer occurred by submitting "any pertinent evidence (for example, legal documents, realtor agreements, and relevant correspondence) with regard to the transfer." N.J.A.C. 10:71-4.10(j)(2).

If it is determined the applicant transferred an asset for less than fair market value during the look-back period to become eligible for Medicaid institutional-level services, the applicant will be subject to a period of Medicaid ineligibility to be imposed once he or she is otherwise eligible for Medicaid benefits. N.J.S.A. 30:4D-3(i)(15)(b); N.J.A.C. 10:71-4.10(c)(4).

Guided by these principles, we affirm substantially for the reasons set forth in the Division's final agency decision, which is supported by sufficient credible evidence in the record as a whole. R. 2:11-3(e)(1)(D). We add the following comments.

The Division did not "disregard" P.L.'s supplemental certification. Rather, the Division correctly noted that while hearsay statements are admissible in contested hearings before the ALJ, "legally competent evidence must exist to support each ultimate finding of fact to an extent sufficient to provide assurances of reliability and to avoid the ... appearance of arbitrariness." See N.J.A.C. 1:1-15.5(b). The Division observed H.L. failed to provide any documentation from the five-year look-back period to support her assertions that the funds paid to P.L. were used for household expenses. The Division further noted the contradictions in the various statements submitted to the ALJ, coupled with the fact that no witnesses testified on behalf of H.L. to explain the discrepancies. Finally, the Division noted that after H.L. was placed in a nursing home there were "at least three separate transfers in the amount[ ] of $1,000 [from her account]" which could not have been contributions for her household expenses at P.L.'s residence as she was no longer living there. In short, H.L. failed to provide evidence to rebut the presumption the transfers were made to qualify for Medicaid eligibility.

***5** We discern no basis to disturb the Division's findings and conclude the decision was not arbitrary, capricious, or unreasonable. To the extent we have not specifically addressed any of H.L.'s remaining arguments, we conclude they lack sufficient merit to warrant discussion in a written opinion. R. 2:11-3(e)(1)(E).

Affirmed.

All Citations

Not Reported in Atl. Rptr., 2023 WL 7985532

Footnotes

1 We assume this letter was misdated as July 21, 2020, and was actually prepared on December 21, 2020, as it was in response to the December 9, 2020 letter from the MCDSS. Moreover, it was stamped received on December 24, 2020.

2 The transactions, totaling $58,000, were cash withdrawals between $700 and $1,800. Most of the funds were between $900 and $1,000 and were primarily withdrawn once per month, but on some occasions multiple withdrawals were made in a single month, and in other months, no cash withdrawals were made. Three $1,000 transactions in 2020—May 7, June 3, and August 7—were direct transfers to H.L.'s son's account.

3 Both H.L. and P.L. initially stated H.L. paid monthly rent in the amount of $875. However, P.L. later certified he did not mean to state that H.L. paid "rent." Rather, he claimed she merely contributed towards "household expenses."

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2023 WL 6931925
Only the Westlaw citation is currently available.
Court of Appeals of Michigan.

Ralph HEGADORN, Personal Representative of the Estate of Mary Ann Hegadorn, Appellee,
v.
LIVINGSTON COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES, Appellant.

No. 356756
|
October 19, 2023, 9:10 a.m.

Synopsis

Background: Wife appealed decision of administrative law judge, which concluded that county department of health and human services properly denied wife's request for Medicaid benefits to pay for her long-term care, based on determination that assets in "solely for the benefit of" (SBO) husband trust were countable assets for Medicaid eligibility purposes. The Circuit Court, Livingston County, reversed, finding that SBO trust assets were not countable because SBO trust was created before department changed its policy regarding SBO trusts. On appeal, the Court of Appeals, 320 Mich.App. 549, 904 N.W.2d 904, reversed the circuit court's decision. The Supreme Court, 503 Mich. 231, 931 N.W.2d 571, reversed and remanded, holding that principal of an irrevocable trust formed solely for the benefit of a community spouse was not per se a resource available to an institutionalized spouse for purposes of Medicaid eligibility. Following ALJ's decision on remand again affirming denial of wife's Medicaid application, the Circuit Court, Livingston County, reversed the ALJ's decision, ordered department to approve wife's application for Medicaid benefits, and denied department's motion for reconsideration. Department appealed.

Holdings: The Court of Appeals, N. P. Hood, J., held that:

fact that husband and wife were married did not necessarily render assets in husband's SBO trust countable for purposes of determining wife's Medicaid eligibility;

fact that wife had assets available to her at time of initial assessment was not conclusive of assets available to wife for purposes of Medicaid eligibility;

trial court was required to determine whether supplemental care trust amounted to a circumstance under which SBO trust was making a payment for wife's benefit for purposes of Medicaid eligibility; and

without supplemental care trust document in record, it could not be determined whether assets placed in SBO trust were countable assets for purposes of wife's Medicaid eligibility.

Affirmed in part, vacated in part, and remanded.

Procedural Posture(s): On Appeal; Review of Administrative Decision.

Livingston Circuit Court, LC No. 20-000171-AA

Before: M. J. Kelly, P.J., and Cameron and N.P. Hood, JJ.

Opinion

N.P. Hood, J.

***1** Appellant Livingston County Department of Health and Human Services (MDHHS) appeals by leave granted [1] the circuit court order reversing the decision of the administrative law judge (ALJ), and awarding Medicaid benefits to the Estate of Mary Ann Hegadorn (the estate), whose personal representative is Ralph Hegadorn (Mr. Hegadorn). The broad issue, as before, is the eligibility of now-deceased Mary Ann Hegadorn (Mrs. Hegadorn or Mary Hegadorn) for long-term care Medicaid benefits and the impact of certain trust documents on her eligibility. The granular and decisive issue is whether there were any circumstances under which the proceeds of the "Ralph D. Hegadorn Irrevocable Trust No. 1 (Sole Benefit Trust)" (Hegadorn SBO Trust) could be paid to Mrs. Hegadorn or for her benefit. This necessarily required consideration of the terms of a second trust that the Hegadorn SBO Trust contemplated creating, but that is not part of the record. On remand, the administrative law judge failed to follow our Supreme Court's direction to address whether there were any circumstances under which Mary Hegadorn could receive the Hegadorn SBO Trust principal. On review, the circuit court answered this question, but misapplied the law to the facts of this case. We therefore affirm the circuit court in part, reverse in part, and remand to the ALJ for further proceedings.

I. BACKGROUND

This case has a long procedural history and this is the second time this case is before this Court. See *Hegadorn v Dep't of Human Servs. Dir.*, 320 Mich App 549, 555, 904 N.W.2d 904 (2017) (*Hegadorn I*), rev'd*Hegadorn vDep't of Human Servs. Dir.*, 503 Mich. 231, 931 N.W.2d 571 (2019) (*Hegadorn II*). The issues in this case turn on the terms of two documents: the Hegadorn SBO Trust and the Special Supplemental Care Trust for Mary Ann Hegadorn (Supplemental Care Trust).

A. HEGADORN APPLIES FOR MEDICAID BENEFITS

On December 20, 2013, Mrs. Hegadorn, an "institutionalized spouse"[2] under the Medicaid program, began receiving long-term care at a nursing home in Howell, Michigan. To be eligible to receive Medicaid long-term benefits to pay for her care, Mrs. Hegadorn's countable assets could not exceed $2,000. To meet this threshold, on January 23, 2014, Mr. Hegadorn, a "community spouse,"[3] established and funded the Hegadorn SBO Trust. Mr. Hegadorn was the trust beneficiary for the Hegadorn SBO Trust. Neither he nor his wife was the trustee or successor trustee. As our Supreme Court observed in *Hegadorn II*, "Section 2.2. of the Hegadorn Trust states that 'Trustee shall distribute the Resources of the Trust at a rate that is calculated to use up all of the Resources during' Mr. Hegadorn's expected lifetime, and it includes a suggested distribution schedule that is based on the [MDHHS's] policies." *Hegadorn II*, 503 Mich. at 240-241, 931 N.W.2d 571. The Hegadorn SBO Trust also lists another trust as a possible residual beneficiary, stating:

> ***2** At my death, if my Spouse is surviving, Trustee shall distribute the remaining trust property to the trustee of the Special Supplemental Care Trust for Mary Ann Hegadorn, created by my Will dated the same day as this Agreement, as my Will may be amended from time to time. [*Id.*, quoting Hegadorn Trust, § 3.3 (formatting altered in *Hegadorn II*, 503 Mich. at 240-241, 931 N.W.2d 571).]

In other words, Mrs. Hegadorn and her husband created the Hegadorn SBO Trust to make her eligible for Medicaid long-term care benefits, and designed it in a way that contemplated Mr. Hegadorn using the trust assets during his life. In the event that he died first, the Hegadorn SBO Trust would fund a new trust, the Supplemental Care Trust. As described below, over this case's procedural history, the administrative apparatus and courts have scrutinized the terms of the Hegadorn SBO Trust. The Supplemental Care Trust, however, does not appear to be part of the record and its terms are unknown.

On April 24, 2014, Mrs. Hegadorn applied for Medicaid benefits to pay for her long-term care. MDHHS denied her application, determining that the assets in the Hegadorn SBO Trust were countable assets, and her countable assets exceeded the applicable financial eligibility limit, known as the community spouse resource allowance (CSRA).[4]

B. HEGADORN APPEALS DENIAL TO ADMINISTRATIVE LAW JUDGE

Mrs. Hegadorn appealed, and following an administrative hearing, the ALJ upheld MDHHS's decision. The ALJ concluded that Mrs. Hegadorn and her husband's combined assets were $487,755.33 when she entered the nursing home on December 20, 2013. *Hegadorn I*, 320 Mich App at 555, 904 N.W.2d 904. The CSRA was fixed at $115,920, leaving countable assets totaling $371,835.33, which would disqualify Mrs. Hegadorn from Medicaid eligibility. *Id.* at 555-556, 904 N.W.2d 904. Regarding these calculations, the ALJ explained that a person's countable assets include "the value of the trust's countable income if there is any condition under which the income could be paid to or on behalf of the person." *Id.* at 556, 904 N.W.2d 904 (quotation marks omitted). And because the Hegadorn SBO Trust required that the trust principal be distributed to Hegadorn's husband during his lifetime, the ALJ concluded that those assets "could be paid to or on behalf of the person," and therefore were countable toward the CSRA. *Id.* Essentially, the ALJ concluded that a trust payment to Hegadorn's husband was effectively a payment for her benefit because of the nature of marriage.

C. CIRCUIT COURT REVERSES ALJ

***3** Mrs. Hegadorn appealed to the Livingston County Circuit Court, which reversed the ALJ's decision and ordered Medicaid benefits to begin as of the date she applied for benefits. *Hegadorn I*, 320 Mich App at 559, 904 N.W.2d 904. The circuit court relied on a MDHHS memorandum from July 2014 to conclude that MDHHS had changed its policy after the trust was established in 2014. See *id.* at 559, 565, 904 N.W.2d 904 (noting the circuit court's reliance on *Hughes v McCarthy*, 734 F.3d 473 (CA 6, 2013) and Michigan Department of Human Services, *Bridges Eligibility Manual (BEM) 401*, 2014-015 (July 1, 2014), p. 11). After the memorandum (*BEM 401*), all SBO trust assets were deemed countable, but the circuit court concluded that trusts established before the memorandum were not countable. *Id.* at 559, 904 N.W.2d 904. The circuit court therefore concluded that the Hegadorn SBO Trust assets were not countable.

D. *HEGADORN I*: COURT OF APPEALS REVERSES CIRCUIT COURT

This Court granted MDHHS's application for leave to appeal and consolidated the case with *Lollar v Dep't of Human Servs Dir* and *Ford v Dep't of Health and Human Servs*, both of which also involved the denial of Medicaid benefits to pay for the long-term care of applicants whose husbands had created SBO trusts. *Hegadorn II*, 503 Mich. at 238, 931 N.W.2d 571; *Hegadorn I*, 320 Mich App at 549, 904 N.W.2d 904. In *Hegadorn I*, this Court upheld the denial in all three decisions, reasoning that the critical issue was whether there was any condition under which the principal of the irrevocable trusts could be paid to or on behalf of the person from an irrevocable trust. *Hegadorn I*, 320 Mich App at 561, 904 N.W.2d 904, citing *BEM 401*. After considering the language of the trusts, which were largely identical as it related to distributions to each husband "or for my sole benefit, during my lifetime," in "an actuarially sound basis," the Court concluded that the trust assets were countable. *Id.* at 563, 904 N.W.2d 904. Relying on *BEM 401* and *BEM 405*, it concluded that the trusts, though designed to be used up by the spouses during their lifetimes, still included a condition under which the principal could be paid to or on behalf of the person from an irrevocable trust," and MDHHS therefore properly determined the assets to be countable. *Id.* at 563, 904 N.W.2d 904, citing Michigan Department of Human Services, *BEM 405*, BPB 2015-0'0 (July 1, 2015), p. 12, and *BEM 401*, p. 12.

E. *HEGADORN II*: SUPREME COURT REVERSES COURT OF APPEALS AND ALJ

Our Supreme Court reversed, finding that both the ALJ and this Court misread the operative statute, 42 USC 1396p(d). *Hegadorn II*, 503 Mich. at 268-269, 931 N.W.2d 571. The Court held that the principal of an irrevocable trust formed solely for the benefit of a community spouse (like the Hegadorn SBO Trust) "is not per se a 'resource available' to an institutionalized spouse under 42 USC 1396r-5(c)(2) for the purpose of determining an institutionalized spouse's eligibility for Medicaid benefits." *Hegadorn II*, 503 Mich. at 264-265, 931 N.W.2d 571.

In reaching its conclusion, the Supreme Court first summarized the two computations required under 42 USC 1396r-5 (providing the treatment of income and resources for institutionalized spouses) to determine whether an institutionalized spouse is eligible for Medicaid benefits: first, the total joint resources during the first continuous period of institutionalization; and second, the resources available to the institutionalized spouse on the date of the application for Medicaid benefits. *Hegadorn II*, 503 Mich. at 250-254, 263-265, 931 N.W.2d 571. The "any-circumstances" inquiry at issue in this case is a component of the second computation. See *Hegadorn II*, 503 Mich. at 262-263, 931 N.W.2d 571.

The first computation determines the total joint resources of the institutionalized spouse and the community spouse " ' 'as of the beginning of the first continuous period of institutionalization,' which may or may not be the same month in which one applies for benefits.' " *Hegadorn II*, 503 Mich. at 250-251, 931 N.W.2d 571, quoting 42 USC 1396r-5(c)(1)(A). MDHHS makes this computation in order to determine the CSRA:

> ***4** One-half of the total value of their countable resources "to the extent either the institutionalized spouse or the community spouse has an ownership interest" is considered a spousal share.
>
> "The spousal share allocated to the community spouse qualifies as the ... CSRA, subject to a ceiling ... indexed for inflation" by Congress. The CSRA is the monetary value of assets that may be retained by or transferred to the community spouse without those resources being counted against the institutionalized spouse for his or her initial eligibility determination. Available resources in excess of the CSRA will generally disqualify an institutionalized

> spouse from receiving Medicaid benefits unless they are spent down prior to filing an application. [*Id.* at 251, 931 N.W.2d 571 (citations omitted).]

The second computation identifies "the resources available to the institutionalized spouse" as of the day they submit the application for Medicaid benefits. *Hegadorn II*, 503 Mich. at 251-252, 931 N.W.2d 571. The agency makes this computation to determine "the institutionalized spouse's initial Medicaid eligibility." *Id.* at 251, 931 N.W.2d 571. " 'In determining the resources of an institutionalized spouse at the time of application for benefits ..., all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse' to the extent that they exceed the CSRA." *Id.* at 252, 931 N.W.2d 571, quoting 42 USC 1396r-5(c)(2)(A) and (B) (emphasis omitted).

The Court explained that the resource allocation provisions of the Medicare Catastrophic Coverage Act, 42 USC 1396r-5, "are silent with regard to the treatment of assets held by a trust." *Hegadorn II*, 503 Mich. at 252, 931 N.W.2d 571. It noted that, as a general legal principle, an irrevocable trust's principal is not available to either the institutionalized spouse or the community spouse because it is held by the trustee. *Id.* at 253-254, 931 N.W.2d 571. But the Court observed, under the Medicaid trust rules, specifically 42 USC 1396p(d), the principal may still be viewed as available to the institutionalized spouse. *Id.* at 254, 931 N.W.2d 571.

Hegadorn II summarized the situations in which a trust resource would be "available" to an institutionalized spouse, as situations satisfying the three criteria under 42 USC 1396p(d):

> [T]he principal of an irrevocable trust formed solely for the benefit of a community spouse is not per se a "resource available" to an institutionalized spouse under 42 USC 1396r-5(c)(2) for the purpose of determining an institutionalized spouse's eligibility for Medicaid benefits. Assets making up the principal of such a trust are not automatically considered countable assets for Medicaid eligibility determinations. However, the principal of an irrevocable trust may become a resource available to an institutionalized spouse, and thus a countable asset, if the following conditions are met: (1) assets of the institutionalized spouse are used to form the principal of the trust, 42 USC 1396p(d)(2)(A); (2) the institutionalized spouse, his or her spouse, or one of the other entities listed under 42 USC 1396p(d)(2)(A)(i) through (iv) established the trust using a means other than a will; and (3) there are "any circumstances under which payment from the trust could be made to or for the benefit of" the institutionalized spouse, 42 USC 1396p(d)(3)(B)(i). [*Hegadorn II*, 503 Mich. at 264-265, 931 N.W.2d 571 (emphasis omitted).]

***5** In other words, the trust principal counts if (1) the institutionalized spouse's assets form the principal, (2) the institutionalized spouse (or their spouse or an entity listed in 42 USC 1396p(d)(2)(A)(i) through (iv)) created the trust through means other than a will,[5] and (3) there are any circumstances under which payment from the trust could be made for the benefit of the institutionalized spouse. See *id.* To make this determination, the Court explained, the agency, ALJ, or court, must examine the language of the trust documents. *Id.* at 265, 931 N.W.2d 571.

Hegadorn II concluded that the first two prongs of this three-prong test were satisfied. *Hegadorn II*, 503 Mich. at 265-266, 931 N.W.2d 571. Mrs. Hegadorn's assets formed the Hegadorn SBO Trust principal, and her husband created the Hegadorn SBO Trust through means other than a will. *Id.* at 265-269, 931 N.W.2d 571.

Regarding the third prong, what the Court described as the "any-circumstances rule," *Hegadorn II* concluded that the ALJ and Court of Appeals' analysis and conclusions relied on a misreading of the federal statutes. *Hegadorn II*, 503 Mich. at 268-269, 931 N.W.2d 571. The Court therefore vacated the final administrative decision and reversed this Court's prior decision. *Id.* at 269, 931 N.W.2d 571. But, acknowledging the complexity of Medicaid and MDHHS's concerns regarding abuse, the Supreme Court declined to rule on whether the third prong was satisfied. *Id.* Instead it remanded to the ALJ, who "may have forgone consideration of alternative avenues of legal analysis." *Id.* at 269, 931 N.W.2d 571. It remanded the case to the ALJ for additional administrative hearings consistent with its opinion, including determining whether there were any circumstances under which the principal of the Hegadorn SBO Trust could be paid for Mrs. Hegadorn's benefit. *Id.* at 269-270, 931 N.W.2d 571.

F. ADMINISTRATIVE DECISION ON REMAND

On remand, the ALJ again affirmed the denial of Mrs. Hegadorn's Medicaid application. In doing so, the ALJ cited sections 2.2 and 3.3 of the Hegadorn SBO Trust:

> 2.2 *Distribution of Resources.* During each fiscal year of the Trust, Trustee shall from time to time during the fiscal year pay or distribute to me, or for my sole benefit, during my lifetime such part of all of the net income and principal ("Resources") of the Trust as Trustee determines is necessary in order to distribute the resources in an actuarilly sound basis....
>
> * * *
>
> 3.3 *Distribution if Spouse Survives.* At my death, if my Spouse is surviving, Trustee shall distribute the remaining trust property to the trustee of the Special Supplemental Care Trust for Mary Ann Hegadorn, created by my Will dated the same day as this Agreement, as my Will may be amended from time to time. [Hegadorn SBO Trust, §§ 2.2 and 3.3 (formatting altered).]

Relying on these provisions, the ALJ concluded that all the trust assets were countable, explaining that because "all assets are expected to be paid to [Mary Ann's] spouse[,] ... there are conditions under which the principal could be paid to or on behalf of [Mary Ann] ...." In sum, the ALJ concluded that the any-circumstances rule had been satisfied, explaining:

> ***6** The Trustee was advised to distribute all the assets on an actuarially sound basis, which for Medicaid purposes means that it must be returned to Petitioner's spouse over his lifetime. BEM, Item 405 pages 11-12. The "available" standard used for assets does not apply to trusts. BEM, Item 400, page 12. Thus, even if the trust had limitations on the yearly amounts, all assets are expected to be paid to Petitioner's spouse so there are conditions under which the principal could be paid to or on behalf of the person and all assets are countable. BEM, Item 401, page 11. If the principal of the trust can be paid to the spouse at some time in the future, *and spouses are responsible for one another*, the condition, however remote, does exist. [Emphasis added.]

Notably, except for the last sentence of the above quoted language, this portion of the ALJ's decision is a verbatim reiteration of a passage included in its earlier 2014 decision. In other words, because Mr. Hegadorn would receive payments from the trust, and spouses are responsible for each other, a payment to Mr. Hegadorn satisfied the any-circumstances rule.

The ALJ also concluded that the Hegadorn SBO Trust was not in "effect until after the initial assessment, which is the determinative factor for what assets are countable for purposes of [the] Medical Assistance eligibility determination"; therefore, Mrs. Hegadorn "retained in excess of $2000 in countable, available assets, which must be counted for purposes of Medical Assistance benefit eligibility ...." This statement related to the first of the two calculations identified in *Hegadorn II*: the total joint resources during the first continuous period of institutionalization. The ALJ ended her analysis there without addressing the separate calculation related to the resources available to the institutionalized spouse the day of the application for Medicaid benefits. See *Hegadorn II*, 503 Mich. at 250-252, 931 N.W.2d 571. As stated above, that day was after the creation of the Hegadorn SBO Trust.

G. CIRCUIT COURT'S REVIEW OF ALJ DECISION ON REMAND

Mr. Hegadorn appealed to the circuit court, and the circuit court reversed the ALJ's decision on remand and ordered MDHHS to approve Mrs. Hegadorn's application for Medicaid benefits. The circuit court noted that the Hegadorn SBO Trust did not provide payment to the institutionalized spouse even in the event of Mr. Hegadorn's death. Rather, the trust language provided that the residual assets would be transferred to a testamentary trust, which, the circuit court concluded, are specifically exempted from the "any-circumstances test" under 42 USC 1396p(d)(3)(B). In its written order, the circuit court made eight explicit findings including four relevant to this appeal:

> 5. [The] Administrative Law Judge decision was affected by a substantial and material error of law, to wit: The ALJ ... did not adhere to the findings by the Michigan Supreme Court, and erroneously determined that the [Hegadorn SBO Trust] was "countable" to Mary Ann Hegadorn (the "institutionalized spouse") because it

could make future payments to Ralph D. Hegadorn (Mary Ann's husband).

6. A trust created by Will is excluded from the "any circumstances" rule of 42 USC 1396p(d)(3)(B)[.]

7. A distribution from the [Hegadorn SBO Trust] to a trust created under Ralph D. Hegadorn's Will (or to the trustee of such a trust) is not a payment from that Sole Benefit Trust to or for the benefit of Mary Ann Hegadorn from the [Hegadorn SBO Trust].

8. No circumstances exist under which payments *from* the [Hegadorn SBO Trust] could be made to or for the benefit of Mary Ann Hegadorn .... [Formatting altered.]

MDHHS moved for reconsideration, and the circuit court denied the motion. This appeal followed.

H. THE SUPPLEMENTAL CARE TRUST

***7** Despite this case's extensive history, our review of the record indicates that a document critical to the ALJ's analysis is not part of the record. As stated, the Hegadorn SBO Trust contains a contingency if Mr. Hegadorn predeceased Mrs. Hegadorn. The trust assets, through the function of Mr. Hegadorn's will, would fund the Supplemental Care Trust. Although this instrument is referenced throughout the record, the document itself and its terms are not part of the record.

II. STANDARD OF REVIEW

This case involves the circuit court's review of an administrative decision. The Michigan Constitution provides that all final decisions of any administrative officer or agency which are judicial or quasi-judicial and affect private rights are subject to direct review by the courts as provided by law. See Const. 1963, art. 6, § 28. "This review shall include, as a minimum, the determination whether such final decisions ... are authorized by law ...." *Id.*

Under the Administrative Procedures Act, MCL 24.201 *et seq.*, unless the law provides a different scope of review, a court may set aside an administrative decision if it violates the constitution or a statute, see MCL 24.306(1)(a), or if the decision is "[a]ffected by other substantial and material error of law," MCL 24.306(1)(f).

We review de novo issues of statutory interpretation. *Hegadorn II*, 503 Mich. at 244-245, 931 N.W.2d 571. We likewise review de novo construction of the language of a trust document. *Id.* at 245, 931 N.W.2d 571.

III. LAW AND ANALYSIS

The circuit court correctly determined that the ALJ erred when it concluded that Ralph Hegadorn's entitlement to benefits under the Hegadorn SBO Trust on its own constituted a circumstance under which Mary Ann Hegadorn might benefit from that trust. It nonetheless erred when it concluded that the Hegadorn SBO Trust funding the Supplemental Care Trust did not constitute a circumstance under which a payment was made for the benefit of Mary Ann Hegadorn. To make this determination the reviewing tribunal would need to review the terms of the Supplemental Care Trust, which is not part of this record.

A. THE CIRCUIT COURT CORRECTLY REVERSED THE ALJ'S APPLICATION OF THE "ANY-CIRCUMSTANCES TEST"

The circuit court correctly concluded that the ALJ misapplied the law as directed by our Supreme Court in *Hegadorn II*. The ALJ made two critical errors. First, like its original review of MDHHS's denial, the ALJ treated Mr. Hegadorn and Mrs. Hegadorn as alter egos to reach the conclusion that a payment from the Hegadorn SBO Trust to Mr. Hegadorn was essentially for Mrs. Hegadorn's benefit. Our Supreme Court explicitly rejected this analysis. *Hegadorn II*, 503 Mich. at 239, 931 N.W.2d 571. Second, the ALJ appears to have relied on only the first of the two required computations for determining Medicaid eligibility. See *id.* at 250-252, 931 N.W.2d 571.

The ALJ's first error was her reliance on the general customary expectation that "spouses are responsible for one another" to reach the legal conclusion that payments from the Hegadorn SBO Trust to Mr. Hegadorn constituted a circumstance, "however remote," under which Mrs. Hegadorn might receive benefit from the trust principal. This reflected a failure to appreciate that spouses retain avenues for obtaining and maintaining separate property, and that the law related to Medicaid eligibility, and estate planning, might and does reflect that.

In *Hegadorn II*, our Supreme Court explicitly rejected this reasoning. It specifically held that a trust's payments to "a community spouse does not automatically render the assets held by the trust countable for the purpose of an institutionalized spouse's initial eligibility determination." *Hegadorn II*, 503 Mich. at 239, 931 N.W.2d 571. In reaching this conclusion, the Court in *Hegadorn II* rejected federal caselaw that rested on the presumption that trust proceeds benefiting one spouse automatically benefit the other. See *Hegadorn II*, 503 Mich. at 268 & n 26, 931 N.W.2d 571 (rejecting the holding in *Johnson v Guhl*, 357 F.3d 403, 409 (3rd Cir. 2004)). In *Johnson v Guhl*, the United States Court of Appeals for the Third Circuit held that the any-circumstances test is satisfied if nothing in the pertinent irrevocable trust specifically prevented the community spouse from sharing payments from it with the institutionalized spouse. *Johnson*, 357 F.3d at 409. *Hegadorn II* disagreed:

> ***8** While the Third Circuit appears to agree that "the individual" refers to an applicant for or recipient of Medicaid benefits, its conclusory analysis disregards the statutory language requiring that the payment be a "payment *from the trust*" that "could be made *to or for the benefit of the individual.*" 42 USC 1396p(d)(3)(B)(i) (emphasis added). The Third Circuit's broad language also effectively reads away any difference in the language used in the § 1396p(d)(3) any-circumstances rule and the § 1382b(e) any-circumstances rule. [*Hegadorn II*, 503 Mich. at 268 n 26, 931 N.W.2d 571, citing *Johnson*, 357 F.3d at 408-409.]

The ALJ therefore erred in concluding that a payment from the Hegadorn SBO Trust to Mr. Hegadorn was effectively for Mrs. Hegadorn's benefit.

The ALJ also erred when it treated as dispositive the fact that the Hegadorn SBO Trust was not in "effect until after the initial assessment, which is the determinative factor for what assets are countable for purposes of [the] Medical Assistance eligibility determination." This led to the conclusion that Mrs. Hegadorn still possessed the assets that funded the Hegadorn SBO Trust and therefore "retained in excess of $2000 in countable, available assets, which must be counted for purposes of Medical Assistance benefit eligibility." This also led the ALJ to end her analysis there. Instead, the ALJ should have addressed the separate calculation regarding resources available as of the day the institutionalized spouse applied for Medicaid benefits. See *Hegadorn II*, 503 Mich. at 250-252, 931 N.W.2d 571. Here, that date was April 24, 2014, after Mr. Hegadorn established the Hegadorn SBO Trust.

Again, the Supreme Court has held that the principal of an irrevocable trust is properly considered a resource available to an institutionalized spouse if "(1) assets of the institutionalized spouse are used to form the principal of the trust; (2) the institutionalized spouse, his or her spouse, or one of the other [statutorily listed] entities established the trust using a means other than a will; and (3) there are 'any circumstances under which payment from the trust could be made to or for the benefit of' the institutionalized spouse." *Hegadorn II*, 503 Mich. at 264-265, 931 N.W.2d 571, citing 42 USC 1396p(d)(2)(A), and quoting 42 USC 1396p(d)(3)(B)(i). With respect to the Hegadorn SBO Trust and Mary Ann Hegadorn, only the third of these factors is at issue. *Hegadorn II*, 503 Mich. at 265-266, 931 N.W.2d 571.

The ALJ's two errors in following our Supreme Court's mandate in *Hegadorn II* prevented her from fully addressing this question: are there any circumstances under which a payment from the trust could be made for the benefit of Mary Ann Hegadorn? Its conclusion ignored the three-prong analysis that *Hegadorn II* explained as necessary under 42 USC 1396p(d) to determine whether the principal of an SBO trust "may become a resource to an institutionalized spouse, and thus a countable asset[.]" *Hegadorn II*, 503 Mich. at 264-265, 931 N.W.2d 571.

B. THE CIRCUIT COURT ERRED BY APPLYING 42 USC 1396P(D)(2)(A)

The circuit court attempted to answer this question, but it reached the wrong conclusion. Although the circuit court correctly concluded that the ALJ erred in applying the law from *Hegadorn II* to the facts of this case, specifically the trust documents, the circuit court erred in concluding that the Supplemental Care Trust, the trust contemplated to be funded by the Hegadorn SBO Trust if Mr. Hegadorn had predeceased Mrs. Hegadorn, could not satisfy the any-circumstances test because it was created by a will.

***9** The circuit court quickly and correctly resolved the question of whether a payment from the Hegadorn SBO Trust to Mr. Hegadorn was effectively a payment to Mrs. Hegadorn. (As stated, it was not.) It then focused the bulk of its any-circumstances analysis on provisions within the Hegadorn SBO Trust that would fund the Supplemental Care Trust for Mrs. Hegadorn in the event that she survived Mr. Hegadorn. It observed that, in the event that the Hegadorn SBO Trust

still had assets upon the death of its sole beneficiary, Ralph Hegadorn, "the residual is transferred to a testamentary trust." Relying on 42 USC 1396p(d)(3)(B), the circuit court concluded that these types of trusts are specifically exempt from the any-circumstance test. This was incorrect.

What our Supreme Court has called the "any-circumstances rule" flows from the language of 42 USC 1396p(d), which provides, in relevant part:

> (1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, ... the rules specified in paragraph (3) shall apply to a trust established by such individual.
>
> (2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:
>
> (i) The individual.
>
> (ii) The individual's spouse.
>
> * * *
>
> [(3)](B) In the case of an irrevocable trust—
>
> (i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—
>
> (I) to or for the benefit of the individual, shall be considered income of the individual, and
>
> (II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c)[.]

Application of the any-circumstances rule requires a court or administrator to "consider not only obvious circumstances, but also those that are hypothetical or even unlikely." *Hegadorn II*, 503 Mich. at 258, 931 N.W.2d 571. The fact that the Hegadorn SBO Trust assets might one day fund the Supplemental Care Trust, which is for Mary Hegadorn's benefit, very well may satisfy the any-circumstances test depending on the terms of the Supplemental Care Trust. The circuit court avoided addressing this issue by relying on the fact that the Supplemental Care Trust is created by a will, and therefore, according to the circuit court, excluded from the any-circumstance test.

This relied on a misreading of the statute. 42 USC 1396p(d)(2)(A) does not provide that a trust created by a will may never be considered a resource benefiting an institutionalized Medicaid applicant. See 42 USC 1396p(d)(2)(A). It only provides that a Medicaid applicant is viewed as establishing a trust if the applicant's assets formed at least part of the trust corpus, and the applicant (or certain others, including their spouse) "established such trust other than by a will." Therefore, if the institutionalized spouse did not establish the trust under subsection (d)(2)(A), then, under 42 USC 1396p(d)(1), the rules provided in 42 USC 1396p(d)(3), including the any-circumstances rule, do not apply. To summarize and simplify, subsection (d)(1) says the rules in (d)(3) only apply to a trust created by an individual. Subsection (d)(2) defines which trusts are deemed to have been created by the individual, and trusts made by wills do not count.

A will created the Supplemental Care Trust, but Hegadorn and her spouse created the Hegadorn SBO Trust. The question, therefore, is not whether there was any circumstance under which the Supplemental Care Trust would make payment for her benefit. Rather, the question is whether the Supplemental Care Trust, through its creation, funding, and terms, amounted to a circumstance under which the Hegadorn SBO Trust is making a payment for her benefit.

***10** The Hegadorns established the Hegadorn SBO Trust in part with Mary Hegadorn's assets and not through function of a will; therefore, the agency and the court had to apply the any-circumstances test. The circuit court correctly concluded that the Hegadorn SBO Trust providing benefits to Mary Ann Hegadorn's spouse, Ralph, was not itself a circumstance that amounted to benefits to Mary Ann. It also correctly focused its inquiry on whether the Supplemental Care Trust satisfied the any-circumstances test. It just never answered the question because it misapplied 42 USC 1396p(d).

We are unaware of, and the parties have not identified, a requirement in the rules or statute that when assets of the SBO trust transfer to another trust, the second trust must also comply with 42 USC 1396p(d)(2). The public policy underlying the omission of such a rule is obvious: if such a requirement existed, the unscrupulous could circumvent Medicaid rules by laundering assets through a shell-game of various irrevocable trusts. Then congressional "efforts

to prevent spousal pauperization while at the same time limiting the ability of wealthier individuals to shelter income and assets using estate planning rules" would be undone. *Hegadorn II*, 503 Mich. at 249, 931 N.W.2d 571.

C. THE MISSING TRUST DOCUMENT

The circuit court's error reveals a broader problem with the ALJ and MDHHS's analysis: the terms of the Supplemental Care Trust are unknown. To our knowledge, the record does not contain a copy of the "Special Supplemental Care Trust for Mary Ann Hegadorn" that the Hegadorn SBO Trust references in Section 3.3. Although the ALJ and circuit court both referenced Section 3.3., neither tribunal, nor the parties have addressed the particulars of the Supplemental Care Trust's terms, such as whether Mary Ann would have held title to the trust assets, be entitled to direct payments, or if the trustee's discretion regarding distributions were otherwise limited. In the context of other types of public assistance, settlors may design trusts with limitations so as not to exclude eligibility for public assistance. See, e.g., Social Security Program Operations Manual System (POMS) SI 01120.200B.12 (providing that a special needs trust beneficiary may be eligible to receive public assistance benefits), available at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200> (accessed September 29, 2023); [6] POMS SI § 01120.200B.13 (describing "spendthrift clauses" which limit a beneficiary's access to trust assets, so that trust assets and payments are not countable as a resource). [7] See also POMS SI § 01120.200B.1 (discretionary trusts). [8] It remains unknown if the Supplemental Care Trust contains such limiting provisions. But it is undisputed that the purpose of the trust is to provide support for Mrs. Hegadorn. *Hegadorn II* instructs that when applying the any-circumstances rule, this Court should "consider not only obvious circumstances, but also those that are hypothetical or even unlikely." *Hegadorn II*, 503 Mich. at 258, 931 N.W.2d 571. At the same time, this Court must consider the language of the trust document. *Id.* at 265, 931 N.W.2d 571. On this record, these two mandates conflict. On its plain terms, Section 3.3 of the Hegadorn SBO Trust contemplates a circumstance under which a payment is made for the benefit of Mary Ann Hegadorn. The nature of that benefit and whether the Supplemental Care Trust is countable is unknowable without the document.

***11** Acknowledging the nuanced calculations required to determine Medicaid eligibility, our Supreme Court remanded this case to the ALJ on the understanding that it dispensed with these calculations due to a legal error. On remand, the ALJ again dispensed with the calculations due to a second closely-related legal error. We now remand to the ALJ a third time, with an even more limited mandate: to review the terms of the Supplemental Care Trust, determine whether under its terms its assets would have been countable in determining Mary Ann Hegadorn's Medicaid eligibility, and to apply the any-circumstances test and calculations described in *Hegadorn II*.

IV. CONCLUSION

For the reasons stated above, we affirm the circuit court's decision reversing the ALJ decision for misapplying *Hegadorn II* to the facts of this case. We reverse the circuit court's decision to the extent its conclusions relied on a misapplication of 42 USC 1396p(d). We remand to the ALJ for further proceedings consistent with this opinion. Specifically, the ALJ is directed to obtain the Supplemental Care Trust, review its terms, and apply the principles of *Hegadorn II* to the facts of this case. We do not retain jurisdiction.

All Citations

--- N.W.3d ----, 2023 WL 6931925

Footnotes

1 *Hegadorn Estate v Livingston Cty Dep't of Health & Human Servs*, unpublished order of the Court of Appeals, entered August 17, 2021 (Docket No. 356756).

2 "An 'institutionalized spouse' is a person who is in a 'medical institution or nursing facility' or who is described in 42 USC 1396a(a)(10)(A)(*ii*)(VI), is likely to meet these requirements 'for at least 30 consecutive days,' and

is married to a person who is not in such a facility." *Hegadorn II*, 503 Mich. at 237 n 2, 931 N.W.2d 571, citing 42 USC 1396r-5(h)(1)(A) and (B).

3 "A 'community spouse' is 'the spouse of an institutionalized spouse.' " *Hegadorn II*, 503 Mich. at 238 n 3, 931 N.W.2d 571.

4 "The spousal share allocated to the community spouse qualifies as the [community spouse resource allowance or] CSRA, subject to a ceiling ... indexed for inflation' by Congress." *Hegadorn II*, 503 Mich. at 251, 931 N.W.2d 571, quoting *Wisconsin Dep't of Health and Family Servs. v Blumer*, 534 U.S. 473, 482, 122 S Ct 962, 151 L Ed 2d 935 (2002). The CSRA is the maximum value of assets that a community spouse can retain (or that can be transferred to the community spouse) without MDHHS counting those resources against the institutionalized spouse or her initial eligibility determination. *Hegadorn II*, 503 Mich. at 251, 931 N.W.2d 571, citing 42 USC 1396r-5(c)(2)(B) and (f); *Blumer*, 534 U.S. at 482-483, 122 S.Ct. 962. If resources exceed the CSRA, an institutionalized spouse will generally be disqualified from receiving Medicaid benefits unless they are spent down prior to filing an application. *Hegadorn II*, 503 Mich. at 251, 931 N.W.2d 571, citing 42 USC 1396r-5(c)(2); *Blumer*, 534 U.S. at 482-483, 122 S.Ct. 962.

5 The Court in *Hegadorn II* also concluded that MDHHS and this Court erred when they determined that the "individual" identified in 42 USC 1396p(d) can be the institutionalized spouse, the community spouse, or the two in combination. *Hegadorn II*, 503 Mich. at 259, 931 N.W.2d 571. The "individual" referred to in the trust rules "is the institutionalized spouse, who is the Medicaid applicant." *Id.* at 255, 931 N.W.2d 571. The Supreme Court concluded that the test of 42 USC 1396p(d)(3)(B) foreclosed any contrary administrative interpretation or application of *BEM 401*.*Id.* at 266-267, 931 N.W.2d 571.

6 POMS SI § 01120.200B.12 provides:

> A special needs trust, also known as a supplemental needs trust, may be set up to provide for a disabled individual's extra and supplemental needs other than food, shelter, and health care expenses that may be covered by public assistance benefits that the trust beneficiary may be eligible to receive under various programs.

7 POMS SI § 01120.200B.13 provides in part:

> A spendthrift clause or spendthrift trust generally prohibits both involuntary and voluntary transfers of the trust beneficiary's interest in the trust income or principal. This means that the trust beneficiary's creditors must wait until the trust pays out money to the trust beneficiary before they can attempt to claim it to satisfy debts.
>
> It also means that, for example, if the trust beneficiary is entitled to $100 a month from the trust, the beneficiary cannot sell his or her right to receive the monthly payments to a third party for a lump sum. In other words, a valid spendthrift clause would make the value of the trust beneficiary's right to receive payments not countable as a resource.

8 POMS SI § 01120.200B.1 provides:

> A discretionary trust is a trust in which the trustee has full discretion as to the time, purpose, and amount of all distributions. The trustee may pay all or none of the trust as he or she considers appropriate to, or for the benefit of, the trust beneficiary. The trust beneficiary has no control over the trust.

219 N.E.3d 166
Court of Appeals of Indiana.

Natalie A. HARVES, BY Richard E. HARVES and Karen Sue (Harves) Cutter, as personal representatives, Appellant-Petitioner,
v.
Daniel RUSYNIAK, in Individual Capacity as Secretary of Indiana Family and Social Services Administration; Indiana Family and Social Services Administration; and Decatur County Division of Family Resources, Appellees-Respondents

Court of Appeals Case No. 23A-PL-671
|
Filed September 26, 2023
|
Rehearing Denied November 27, 2023

Synopsis

Background: Unsuccessful applicant for Medicaid nursing-home benefits petitioned for judicial review of decision of Family and Social Services Administration's (FSSA) denial of benefits. The Decatur Circuit Court, No. 16C01-2007-PL-292, David Northam, Special Judge, denied petition. Applicant appealed.

Holdings: The Court of Appeals, Vaidik, J., held that:

only if a Medicaid applicant is otherwise eligible does federal Medicaid statute governing treatment of trust accounts require FSSA, in determining eligibility for Medicaid nursing-home benefits, to look back to determine if any uncompensated or undercompensated transfers of assets were made, and

before the corpus of an irrevocable trust can be counted as "available resources," in determining an applicant's eligibility for Medicaid nursing-home benefits, there must be circumstances under which payment from the trust could be made to or for the benefit of the individual.

Reversed and remanded with instructions.

Procedural Posture(s): On Appeal; Review of Administrative Decision.

***167** Appeal from the Decatur Circuit Court, The Honorable David Northam, Special Judge, Trial Court Cause No. 16C01-2007-PL-292

Attorneys and Law Firms

Attorney for Appellant: Michael T. Foster, Greensburg, Indiana

Attorneys for Appellees: Theodore E. Rokita, Attorney General, Evan Matthew Comer, Deputy Attorney General, Indianapolis, Indiana

Vaidik, Judge.

Case Summary

[1] Natalie A. Harves applied for Medicaid nursing-home benefits. The Indiana Family and Social Services Administration (FSSA) denied her application, and after an unsuccessful administrative appeal, Harves petitioned for judicial review.[1] The trial court denied the petition, and Harves appeals. We reverse and remand to the trial court with instructions to grant the petition for judicial review and return the matter back to FSSA for further proceedings.

Facts and Procedural History

[2] This case concerns several documents that Harves and her children—Karen Sue Cutter, Richard E. Harves, and Ann Harves Bildner—signed on January 25, 2019, when Harves was ninety-one years old. First, Harves appointed Karen as her "Health Care Surrogate" and attorney-in-fact and appointed Richard and Ann as the successor surrogates and attorneys-in-fact. Second, Harves, Karen, and Richard signed a "Personal Service Contract" in which Harves indicated her intent to ***168** compensate the children for "the time and expenses incurred" by the children "in providing me with assistance and supervision in managing the affairs of my estate, or in providing me with financial management, home health care, nursing care and escort services as required because of my failing health regardless of whether such services were skilled or unskilled[.]" Appellant's App. Vol. II p. 82. According to Harves, the children gave her nearly $900,000 in services from January 2011 to January 2019 and continued providing services after the Personal Service Contract was signed. The contract included the following provision:

> CONSOLIDATE ASSETS. I further agree that I have appointed an attorney-in-fact in a Power of Attorney executed by me to consolidate my liquid and semi-liquid assets into common account(s) held by my living trust or such other trust agreement as my health care agent may elect, provided such alternative trust has the identical beneficiaries as my living trust[.]

Id.

[3] Third, the children signed an agreement creating an irrevocable trust, the N. Harves Family Heirs Trust ("the Trust"), and Harves's assets—worth $557,240, according to Harves—were placed in the Trust. The trust agreement named Karen and Richard as the trustees and began with the provisions below tying the Trust to the Personal Service Contract:

> A. (TRUST BENEFICIARIES) WHEREAS, the Trust-maker(s) desire to establish a trust for the segregation, management and distribution of any property transferred as consideration and reimbursement to the trust makers by a payor of any and all health care and assistance [herein after Healthcare Services Recipient], either skilled or unskilled, provided by any one or more of the trust makers; and
>
> B. (TRUST ASSETS) WHEREAS, concurrently with the execution of this Trust Agreement, or as soon as possible thereafter, all of the right, title and interest in and to the property described in the annexed Schedule A shall be transferred to the Trustee as the property belonging to this trust estate; and
>
> C. (TRUST PURPOSE) WHEREAS, the intent of the Trust is curtail [sic] any and all interest of any health care recipient in the assets transferred to the Trust estate; and to avoid any constructive receipt of the trust assets to the trust makers during the life of any payor of the health care services provided by any one of the trust makers....

Id. at 52.

[4] Four months later, in May 2019, Harves applied for Medicaid nursing-home benefits. FSSA denied the application, finding that the assets of the Trust are available to Harves and that as a result her resources exceed the threshold for Medicaid eligibility. Harves filed an administrative appeal, and an administrative law judge (ALJ) affirmed the denial. After FSSA issued a Notice of Final Agency Action affirming the ALJ's order, Harves petitioned for judicial review. The trial court denied the petition and affirmed the ALJ's determination.

[5] Harves now appeals.

Discussion and Decision

[6] Harves argues the ALJ and trial court erred by finding that the assets of the Trust are resources available to her, making her ineligible for Medicaid nursing-home benefits.[2] In an appeal following ***169** a trial court's review of an agency decision, we stand in the shoes of the trial court and owe no deference to its determination. *Baliga v. Ind. Horse Racing Comm'n*, 112 N.E.3d 731, 736 (Ind. Ct. App. 2018), *reh'g denied*, *trans. denied.* The burden of demonstrating the invalidity of agency action is on the party asserting invalidity, and we will reverse only if the agency action was

> (1) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (2) contrary to constitutional right, power, privilege, or immunity; (3) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right; (4) without observance of procedure required by law; or (5) unsupported by substantial evidence.

Ind. Code § 4-21.5-5-14. We defer to the expertise of the administrative body, we may not try the case de novo or substitute our judgment for that of the agency, and we will not reweigh the evidence. *Brown v. Ind. Fam. & Soc. Servs. Admin.*, 45 N.E.3d 1233, 1235-36 (Ind. Ct. App. 2015).

[7] The Medicaid program, 42 U.S.C. § 1396 et seq., was established by Congress in 1965. As we have explained:

> Its purpose is to provide medical assistance to needy persons whose income and resources are insufficient to meet the expenses of health care. The program operates through a combined scheme of state and federal statutory and regulatory authority. States participating in the Medicaid program must establish reasonable standards for determining eligibility, including the reasonable evaluation of an applicant's income and resources. To qualify for Medicaid, an applicant must meet both an income-eligibility test and a resources-eligibility test. If either the applicant's income or the value of the applicant's resources is too high, the applicant does not qualify for Medicaid.

Id. at 1236 (citations omitted).

[8] "Medicaid is a rocky terrain and that terrain is even more treacherous" where, as here, an irrevocable trust is involved. *Id.* at 1237.

> For the first two decades of Medicaid, an irrevocable trust was not considered an asset in determining whether an applicant was sufficiently needy to qualify for Medicaid benefits. During this time, financial advisors and attorneys advised their clients to shelter their assets in irrevocable trusts because a trust settlor was able to qualify for public assistance without depleting his assets. He could therefore once more enjoy those assets if he no longer needed public assistance; and, if such a happy time did not come, could let them pass intact pursuant to the terms of the trust to his heirs. In other words, the settlor "was able to have his cake and eat it too."
>
> In 1986, Congress closed this "loophole" in the Medicaid act so that assets in certain trusts would be considered in determining whether a Medicaid applicant satisfied the maximum asset requirement. Seven years later, Congress enacted even tighter restrictions, which expanded the types of trusts that could ***170** be considered to preclude applicants from Medicaid eligibility.

Id. at 1236-37 (cleaned up).

[9] Here, in finding that the assets of the Trust are available resources for Harves, the ALJ relied on subsection (d) of 42 U.S.C. § 1396p, titled "Treatment of trust amounts." That provision states, in relevant part, that the corpus of an irrevocable trust "shall be considered resources available to the individual" if

> (1) assets of the individual were used to form all or part of the corpus of the trust;
>
> (2) any of the following individuals established such trust other than by will: the individual; the individual's spouse; a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or a person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse; and
>
> (3) there are any circumstances under which payment from the trust could be made to or for the benefit of the individual[.]

42 U.S.C. § 1396p(d)(1), (2)(A), (3)(B)(i).

[10] Harves argues the ALJ should have instead analyzed the Trust under subsection (c) of the statute, entitled "Taking into account certain transfers of assets." Paragraph (c)(1) provides, in relevant part, that if an institutionalized individual disposed of assets for less than fair market value on or after the statutory "look-back date" (generally, five years before applying for Medicaid), the individual will be ineligible for Medicaid nursing-home benefits for a certain number of months. 42 U.S.C. § 1396p(c)(1)(A)-(E). However, subparagraph (c)(2)(C) provides that an individual is not ineligible under paragraph (c)(1) if a satisfactory showing is made that

> (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair

> market value have been returned to the individual[.]

Id. at (c)(2)(C). Harves contends that clause (i) applies. Specifically, she asserts that her assets were placed in the Trust to compensate her children for the services they provided her over the years, as envisioned by the Personal Service Contract, and that therefore she disposed of the assets "for other valuable consideration."

[11] This puts the cart before the horse. Only if a Medicaid applicant is otherwise eligible does subsection (c) require FSSA to look back "to determine if any uncompensated or undercompensated transfers of assets were made." *Brown*, 45 N.E.3d at 1236. In other words:

> FSSA makes two decisions when deciding the amount of medical assistance an individual receives to meet the expenses of health care. First FSSA determines eligibility based on the available resources of the individual.... Second, if an individual is found eligible for Medicaid benefits, the FSSA may impose a transfer penalty if any uncompensated or under-compensated transfers of assets were made.

Id. at 1237 (footnote omitted). Applied to Harves's situation, this means that before determining whether the transfer of her assets to the Trust made her ineligible under subsection (c), it must first be determined whether the transfer made the assets unavailable to her. If it didn't, she is ***171** already ineligible, and ineligibility under the look-back provisions of subsection (c) is a nonissue.

[12] That brings us back to subsection (d) of the statute, and here we find a significant error in the ALJ's analysis. The ALJ concluded that the corpus of the Trust must be considered resources available to Harves after finding that (1) Harves's assets were used to form the corpus of the Trust and (2) the Trust was established by a person with legal authority to act on behalf of Harves. Appellant's App. Vol. II pp. 25-26. Those two findings were correct. Harves acknowledges that "[a]ll of [her] assets were transferred to the [Trust]," Appellant's Br. p. 15, and Karen—Harves's daughter and attorney-in-fact—established the Trust along with Harves's other children. But as noted above, a third element must be satisfied before the corpus of an irrevocable trust can be counted as available resources. That is, there must be circumstances under which payment from the trust could be made to or for the benefit of the individual. 42 U.S.C. § 1396p(d)(3)(B)(i). In her order, the ALJ did not mention that element or discuss any language from the trust agreement that might satisfy it. Appellant's App. Vol. II pp. 16-28.[3] Similarly, the trial court did not address the element in denying Harves's petition for judicial review. *Id.* at 34-42.

[13] The parties address this third element in their appellate briefs, disputing whether certain provisions in the trust agreement mean that payment from the Trust could be made to Harves or for her benefit. But the agency, not this Court, must adjudicate this issue in the first instance.

> A simple but fundamental rule of administrative law is to the effect that a reviewing court, in dealing with a determination or judgment which an administrative agency alone is authorized to make, must judge the propriety of such action solely by the grounds invoked by the agency. If those grounds are inadequate or improper, the court is powerless to affirm the administrative action by substituting what it considers to be a more adequate or proper basis.

Dev. Servs. Alternatives, Inc. v. Ind. Fam. & Soc. Servs. Admin., 915 N.E.2d 169, 187 (Ind. Ct. App. 2009) (quoting *SEC v. Chenery Corp.*, 332 U.S. 194, 196, 67 S.Ct. 1760, 91 L.Ed. 1995 (1947)), *trans. denied.* "Remanding the case to the administrative body gives it an opportunity to correct the irregularities in its proceedings as determined by the court. At the same time, it avoids the court's encroachment upon the agency's administrative functions." *Ind. Alcoholic Beverage Comm'n v. Edwards*, 659 N.E.2d 631, 636 (Ind. Ct. App. 1995) (cleaned up); *see also Shoot v. Ind. Fam. & Soc. Servs. Admin.*, 691 N.E.2d 1290, 1293 (Ind. Ct. App. 1998) ("[T]he sole relief either the trial court or the appellate court may grant if an administrative decision is found to be unlawful is to vacate the decision and remand for further determination

by the agency."). Therefore, we must reverse the denial of the petition for judicial review and remand to the trial court with instructions to grant the petition and return the matter back to FSSA for further ***172** proceedings on the third element. [4]

[14] Reversed and remanded.

Mathias, J., and Pyle, J., concur.

All Citations

219 N.E.3d 166

Footnotes

1 Harves died a few days after FSSA's initial denial of her application, and her family pursued the case on her behalf, but for simplicity's sake, this opinion will refer to Harves as the petitioner and appellant.

2 FSSA found Harves ineligible for three reasons: "VALUE OF RESOURCES EXCEEDS PROGRAM ELIGIBILITY STANDARD"; "INCOME EXCEEDS ELIGIBILITY STANDARDS"; "REFUSAL TO AGREE TO SELL OR RENT NON-EXEMPT REAL PROPERTY." Appellant's App. Vol. II p. 213. FSSA contends that Harves doesn't challenge the second and third grounds, that those grounds are independent bases for the denial, that Harves will therefore be ineligible for Medicaid even if she is correct on the available-resources issue, and that as a result we can affirm without addressing this issue. Harves responds that the real property and the income from the real property belong to the Trust and that as a result "inclusion of the [Trust] caused the denial on these other two grounds." Appellant's Reply Br. p. 7. FSSA gives us no reason to question that assertion, so we will address the merits of Harves's appeal.

3 At one point in her order, the ALJ stated, "The N. Harves Family Heirs Trust was created for the sole benefit of a Disabled Appointee." Appellant's App. Vol. II p. 25. In the trial court, FSSA acknowledged that the Trust "does not appear to say anything about a disabled appointee" and argued that the court "should disregard this portion of the ALJ's conclusion of law as harmless error." Appellant's App. Vol. III p. 172.

4 Harves's petition for judicial review also included a claim for "42 U.S.C. § 1983 Civil Rights Relief" and a corresponding request for attorney's fees under 42 U.S.C. § 1988. Appellant's App. Vol. III pp. 22-26. The trial court granted summary judgment to FSSA on those issues. On appeal, Harves makes a three-sentence argument that she is entitled to attorney's fees under Section 1988 but doesn't address the merits of the trial court's summary-judgment order on the underlying Section 1983 claim. We therefore affirm the trial court on these issues.

2023 WL 6215794
Only the Westlaw citation is currently available.
United States District Court, E.D. California.

Billie DOAN, Plaintiff,
v.
Kilolo KIJAKAZI, Acting Commissioner of Social Security, Defendant.

Case No. 2:22-cv-00084-JDP (SS)
|
Signed September 21, 2023
|
Filed September 25, 2023

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ORDER

JEREMY D. PETERSON, UNITED STATES MAGISTRATE JUDGE

***1** Plaintiff seeks judicial review of a final decision of the Commissioner of Social Security ("Commissioner") finding that she was ineligible to receive Supplemental Security Insurance ("SSI") benefits that she had previously been awarded. Both parties have moved for summary judgment. ECF Nos. 14 & 15. For the reasons discussed below, plaintiff's motion for summary judgment is granted, the Commissioner's motion is denied, and this matter is remanded for immediate payment of benefits.

Standard of Review

An Administrative Law Judge's ("ALJ") decision denying an application for disability benefits will be upheld if it is supported by substantial evidence in the record and if the correct legal standards have been applied. *Stout v. Comm'r, Soc. Sec. Admin.*, 454 F.3d 1050, 1052 (9th Cir. 2006). " 'Substantial evidence' means more than a mere scintilla, but less than a preponderance; it is such relevant evidence as a reasonable person might accept as adequate to support a conclusion." *Lingenfelter v. Astrue*, 504 F.3d 1028, 1035 (9th Cir. 2007).

"The ALJ is responsible for determining credibility, resolving conflicts in medical testimony, and resolving ambiguities." *Edlund v. Massanari*, 253 F.3d 1152, 1156 (9th Cir. 2001) (citations omitted). "Where the evidence is susceptible to more than one rational interpretation, one of which supports the ALJ's decision, the ALJ's conclusion must be upheld." *Thomas v. Barnhart*, 278 F.3d 947, 954 (9th Cir. 2002). However, the court will not affirm on grounds upon which the ALJ did not rely. *Connett v. Barnhart*, 340 F.3d 871, 874 (9th Cir. 2003) ("We are constrained to review the reasons the ALJ asserts.").

Background

Plaintiff was previously awarded SSI benefits under Title XVI of the Social Security Act. Administrative Record ("AR") 26. On May 15, 2018, the Social Security Administration ("SSA") notified plaintiff that, due to becoming the beneficiary of a special needs trust, she no longer met the resource limitations for SSI and was now ineligible for benefits. AR 153-88. The SSA also issued a notice of overpayment, informing plaintiff that she owed $23,306.84 for payments she received for the months of April 2016 through April 2018. AR 192-96. After plaintiff's request for reconsideration was denied, plaintiff appeared and testified at a hearing before an administrative law judge ("ALJ"). AR 33-41, 199-202.

On May 21, 2019, the ALJ issued an unfavorable decision, finding that plaintiff's special needs trust was a countable resource because it failed "to include proper State(s) Medicaid plan(s) reimbursement requirement"—a requirement of the countable resource trust exemption at 42 U.S.C. § 1396p(d)(4)(A). AR 23-30. The Appeals Council then denied plaintiff's request for review. AR 1-7. She now seeks judicial review under 42 U.S.C. §§ 405(g), 1383(c)(3).

Analysis

To be eligible for SSI, a claimant must satisfy a financial need requirement. For unmarried individuals, their countable resources cannot exceed $2,000. 42 U.S.C. § 1382(a)(3); 20 C.F.R. § 416.1205(c). Countable resources include "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." 20 C.F.R. § 416.1201. Although a trust is ordinarily a countable resource, irrevocable special needs trusts are exempted if they meet certain criteria. 42 U.S.C. §§ 1382b(e), 1396p(d)(4)(A). Specifically, section 1396p(d)(4)(A) exempts:

> ***2** A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by the individual, a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

42 U.S.C. § 1396p(d)(4)(A).

In his decision, the ALJ found that plaintiff was a disabled individual under the age of 65 and that her special needs trust was established by a court. AR 28. The ALJ, however, concluded that the trust was not an exempt resource because it provided "solely for reimbursement to California" for any medical assistance benefits that the state provided to plaintiff. *Id*. at 28-29. He determined that the trust's failure to provide reimbursement for "any and all states" was contrary to Program Operations Manual System ("POMS") SI 01120.203, which requires that a trust "contain specific language that provides that, upon the death of the individual, the State(s) will receive all amounts remaining in the trust, up to an amount equal to the total amount of medical assistance paid on behalf of the individual under the State Medicaid plan(s)." [1] *Id*.

Plaintiff argues that the trust satisfied section 1396p(d)(4)(A) and that the ALJ improperly relied on POMS guidance to find the special needs trust non-compliant. ECF No. 14-1. She contends that, because the statute is unambiguous, POMS is not entitled to deference and therefore the ALJ erred by relying on the manual's guidance. *Id.* at 8-11. Alternatively, she argues that even if the statute is ambiguous, POMS impermissibly adds a requirement to the statute. *Id.* at 11-12. Finally, she contends that her trust complied with POMS both on its face, because the trust expressly provides that states other than California have a right to reimbursement, and in practice, because California is the only state from which plaintiff has received medical assistance. *Id*. at 13-15.

POMS "does not impose judicially enforceable duties" on either the courts or ALJs. *Lockwood v. Comm'r Soc. Sec.*, 616 F.3d 1068, 1073 (9th Cir. 2010). Nevertheless, it may be 'entitled to respect' ... "to the extent it provides a persuasive interpretation of an ambiguous regulation." *Carillo-Years*, 671 F.3d at 735. The Northern District of Ohio recently addressed whether § 1396p(d)(4)(A) is ambiguous and whether POMS's interpretation of that statute is therefore entitled to deference. In *Huffman v. Comm'r of Soc. Sec.*, No. 3:20-cv-2300, 2022 WL 2611425 (N.D. Ohio Apr. 18, 2022), the court observed that:

> Subsection (d)(4)(A) unambiguously imposes a requirement that a benefit recipient who has a special needs trust must ensure that the trust must reimburse the state that provides benefits if the individual dies while trust assets remain .... If we examine the section more broadly, "the State" refers to the particular state which determined the Medicaid applicant's eligibility. But subsection (d)(1) also specifies that "For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this title [42 U.S.C. §§ 1396 et seq.] subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual." 42 U.S.C. § 1396p(d)(1) (alteration in original). The use of the indefinite article "a" denotes that any state may serve in the role. Quite plainly, § 1396p, given common canons of construction, refers to both individual states and multiple states.
>
> ***3** Such a reading is consistent with 1 U.S.C. § 1's provision that, unless the context indicates otherwise, "words importing the singular include and apply to several person, parties or things." And "words importing the plural include the singular." *Id*. Applying these common, well-established rules of

> construction, we must conclude that when subsection (d)(4)(A) only excepted special needs trusts that required reimbursement to "the State," it meant that a person who had received benefits from multiple states was obligated to ensure that his special needs trust reimbursed the states from which benefits were received. And it also meant that a person who received benefits from a single state was obligated to reimburse that state. In other words, the statute plainly required that the benefit-providing states be reimbursed; there is no ambiguity in that at all.
>
> This reading of subsection (d)(4)(A) is consistent with the statute's statutory purpose. Special needs trusts are intended to provide for the expenses of disabled individuals that state and federal assistance programs do not. In essence, § 1396p(d)(4)(A) created an incentive for states to exclude these resources from an individual's assets in determining their eligibility by allowing those states which do provide medical benefits to an individual to have a claim on those assets should the individual die before the trust is fully distributed.
>
> Accordingly, the statute unambiguously requires that, in order to be excluded as a resource, a special needs trust under subsection (d)(4)(A) must provide for the payback of medical assistance to a state (plural or singular) that provides benefits.

Id. at *6-7 (some internal citations omitted).

The court finds *Huffman*'s reasoning persuasive and likewise concludes that section 1396p(d)(4)(A) is not ambiguous. Consequently, the court does not defer to POMS 01120.203 in interpreting § 1396p(d)(4)(A).

The statute unambiguously requires that the trust provide for reimbursement to any state that has paid benefits to the trust beneficiary upon their death. The Commissioner does not dispute that plaintiff has only received medical benefits from California. Nevertheless, the Commissioner argues that "there was no way of knowing how many states a beneficiary may live in during her lifetime, and allowing a trust to limit reimbursement to a single state would frustrate the purpose of the [special needs trust] exception." ECF No. 15 at 6. The first assertion is inaccurate: as the SSA informed plaintiff, SSI recipients are required to report where they live and whether they are eligible for benefits other than SSI, and the SSA is entitled to "redetermine your eligibility when you tell us (or we otherwise learn) of a change in your situation which affects your eligibility or the amount of your benefit." 20 C.F.R. § 416.204; *see* AR 60. The second assertion would be true in the case where a special needs trust limited reimbursement solely to one state and the beneficiary received medical benefits from another state. But that scenario is not present here. In the absence of such facts, the Commissioner's narrow interpretation of the statute and trust language amount to an undue hardship on plaintiff, contravening the humanitarian purpose of the Social Security program and the trust exemption statute itself, which provides for the waiver of any provision that "would work an undue hardship on the individual." 42 U.S.C. § 1396p(d)(5); *see Stephens v. U.S. R.R. Ret. Bd.*, 704 F.3d 587, 591 (9th Cir. 2012) ("The Social Security Act 'is remedial and its humanitarian aims necessitate that it be construed broadly and applied liberally.' ") (quoting *Adams v. Weinberger*, 521 F.2d 656, 659 (2d Cir. 1975)).

Consistent with § 1396p(d)(4)(A)'s requirements, paragraph 4.8.1.1 of the trust provided that, upon the death of the beneficiary, the "Trustee shall pay the State of California"—the only state that provided medical assistance under any state Medicaid plan—"up to an amount equal to the total medical assistance paid on behalf of the Beneficiary under the State plan." AR 75. And, consistent with the requirement that state Medicaid reimbursement "not be limited to any particular State(s)," the paragraph contains no limiting provision. Additionally, paragraph 5.2 provides that "[u]pon termination of the trust ... [t]he State of California *or any other state* shall be entitled to receive all amounts remaining in the Trust up to an amount equal to the total medical assistance paid on behalf of the Beneficiary under the State plan." AR 76. Finally, in the definition section, the trust expressly defines "the Medi-Cal Program of the State of California [to] include[ ] any other states's [sic] Medicaid Program equivalent." AR 81. The trust listed the State of California because it had paid benefits to plaintiff, but it complied with § 1396p(d)(4)(A) insofar as it did not exclude any other state from making reimbursement claims upon termination of the trust.

***4** Other provisions in the trust support this conclusion. Paragraph 1.2 states that the trust agreement was established for the benefit of an individual with a disability in accordance with § 1396p and POMS SI 01120.199 through 01120.203. AR 66. Paragraph 3.1 states that the purpose of the trust is: "to provide financial aid that is supplemental to, rather than a replacement for, various public benefits available to the Beneficiary, without affecting the benefits that would be available to the Beneficiary if the Trust did not exist." AR

69. Paragraph 3.1 instructs that the special needs trust must be interpreted in light of that purpose and in recognition of the likelihood that termination of public benefits would cause the trust to be depleted and, in turn, deprive plaintiff of essential coverage to "maintain an adequate level of human dignity and humane care." AR 70. Other provisions obligate the trustee to manage the trust in compliance with these laws and in any other manner necessary to preserve plaintiff's eligibility for public benefits. *See* Paragraph 4.5 ("[T]he Trustee shall administer the Trust so as to encourage support and maintenance for the Beneficiary from all available public benefits programs."); Paragraph 4.6 ("The Trustee may, in the Trustee discretion, take necessary administrative or legal steps to protect the Beneficiary's eligibility for Medi-Cal and other public benefits programs.").

Only an unreasonably narrow interpretation of the trust's language supports the conclusion that its effect upon termination would be "to limit reimbursement to a single state." ECF No. 15 at 6. And such an interpretation conflicts with one of the bedrock principles of trust construction: that it must be read as a whole with the intent of the maker in mind and favoring any interpretation that would avoid forfeiture. *See Brock v. Hall*, 33 Cal. 2d 885, 887 (1949) ("[T]he duty of the court in all cases of interpretation is to ascertain the intention of the maker from the instrument read as a whole and to give effect thereto if possible."); *Ballard v. MacCallum*, 15 Cal. 2d 439, 444 (1940) (explaining that where there are "two possible constructions, one of which leads to a forfeiture and the other avoids it[,] ... the construction which avoids forfeiture must be made if it is at all possible"); *see also Davidson v. Colvin*, No. CV 12-09968-DFM, 2014 WL 934527, at *3 (C.D. Cal. Mar. 10, 2014) ("To the extent there is any ambiguity in the trust's provisions they are clarified by the trust's statement of intent, which expressly states that the trust is intended to comply with federal law governing the requirements for a special needs trust under the SSA.").

Accordingly, the ALJ erred in finding that plaintiff's special needs trust was not an exempt asset. As a result, plaintiff's SSI benefits were improperly terminated, and an overpayment was incorrectly assessed. Plaintiff is entitled to her full SSI benefits, the payment of any benefits improperly withheld, and the return of any moneys paid due to the erroneous overpayment determination. Her motion for summary judgment is granted, the Commissioners is denied, and this matter is remanded for immediate payment of benefits.

Accordingly, it is hereby ORDERED that:

1. Plaintiff's motion for summary judgment, ECF No. 14, is granted.

2. The Commissioner's cross-motion for summary judgment, ECF No. 15, is denied.

3. The matter is remanded for immediate calculation of benefits.

4. The Clerk of Court is directed to enter judgment in plaintiff's favor.

IT IS SO ORDERED.

All Citations

Slip Copy, 2023 WL 6215794

Footnotes

1 POMS is "an internal agency document used by employees to process claims." *Carillo-Years v. Astrue*, 671 F.3d 731, 735 (9th Cir. 2011).

2023 WL 6060044
Only the Westlaw citation is currently available.
United States District Court, E.D. California.

D.C., an incompetent adult; BY AND THROUGH his guardian ad litem DeNeice MURPHY, Plaintiff,
v.
MODESTO CITY SCHOOLS and Stanislaus County Office of Education, Defendants.

Case No. 1:22-cv-01481-HBK
|
Signed September 18, 2023

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ORDER GRANTING JOINT PETITION FOR INCOMPETENT'S COMPROMISE [1]

(Doc. No. 1)

HELENA M. BARCH-KUCHTA, UNITED STATES MAGISTRATE JUDGE

***1** Before the Court is a Joint Petition for Approval of Incompetent's Compromise filed by the minor Plaintiff D.C., by and through his guardian ad litem, DeNeice Murphy ("Plaintiff") and Modesto City Schools and Stanislaus County Office of Education (collectively "Defendants"). ("Petition," Doc. No. 1). The Court found the Petition appropriate for resolution without a hearing (Doc. No. 15). *See* Fed. R. Civ. P. 78(b); L.R. 230(g). Having considered the papers filed in support of the Petition and controlling law, the Court GRANTS the Petition. L.R. 202(b)(2).

PROCEDURAL BACKGROUND

On April 28, 2021, Plaintiff D.C., an incompetent male adult, by and through his mother and guardian ad litem DeNeice Murphy, filed a Second Amended Special Education Due Process Complaint Notice hearing with the Office of Administrative Hearings ("OAH") pursuant to 20 U.S.C. § 1415(b)(7)(A) against Defendants Modesto City Schools and Stanislaus County. ("Complaint," Doc. No. 1-1). The Complaint alleged violations of special education laws against the Defendants from approximately April 2020 through April 2022. (*Id.*). Due to these alleged deficiencies, and without any educational plan to support him during the COVID-19 pandemic, D.C. suffered damages, became homeless, and was incarcerated. (*Id.*). Defendants deny any wrongdoing. (Doc. No. 1 at 4).

On August 17, 2022, the parties participated in a settlement with OAH. (*Id.*). Eventually, the parties reached a global settlement on September 20, 2022. (*Id.*, "Agreement"). A copy of the Agreement is attached as Exhibit 2 to the Petition. (Doc. No. 1-2). The OAH has continued the due process hearing pending the Court's approval of the Agreement. (Doc. No. 1 at 4).

On August 30, 2023, Plaintiff filed a Status Report advising that Plaintiff was released from the Stanislaus County jail on June 16, 2023, placed on psychiatric hold, and then transferred to a Stanislaus County Psychiatric Health Facility. (Doc. No. 17 at ¶¶ 1, 4). He currently lives with his mother, DeNeice Murphy, who continues to work with a private psychiatrist to find therapeutic medication to address D.C.'s current presentment of issues. (*Id.*, ¶¶2, 6). D.C. has not expressed an interest in returning to any school-based program despite Defendants' willingness to continue to provide educational services. (*Id.*, ¶8).

APPLICABLE LAW

When reviewing settlements with minors or an incompetent person, "have a special duty, derived from Federal Rule of Civil Procedure 17(c), to safeguard the interests of [such] litigants." *Robidoux v. Rosengren*, 638 F.3d 1177, 1181 (9th Cir. 2011). This requires the court to "independently investigate and evaluate any compromise or settlement of a minor's [2] claims to assure itself that the minor's interests are protected, even if the settlement has been recommended or negotiated by the minor's parent or guardian ad litem." *Salmeron v. U.S.*, 724 F.2d 1357, 1363 (9th Cir. 1983) (citation omitted).

***2** Local Rule 202(b) mandates "[n]o claim by or against a minor or incompetent person may be settled or compromised absent an order by the Court approving the settlement or compromise." "In actions in which the minor or incompetent is represented by an appointed representative pursuant to appropriate state law, excepting only those actions in which the United States courts have exclusive jurisdiction, the settlement or compromise shall first be approved by the state court having jurisdiction over the personal representative." L.R. 202(b)(1). In all other actions, the motion for approval of a proposed settlement shall be filed pursuant to Local Rule 230, and must disclose, among other things, the following:

> the age and sex of the minor or incompetent, the nature of the causes of action to be settled or compromised, the facts and circumstances out of which the causes of action arose, including the time, place and persons involved, the manner in which the compromise amount or other consideration was determined, including such additional information as may be required to enable the Court to determine the fairness of the settlement or compromise, and, if a personal injury claim, the nature and extent of the injury with sufficient particularity to inform the Court whether the injury is temporary or permanent. If reports of physicians or other similar experts have been prepared, such reports shall be provided to the Court. The Court may also require the filing of experts' reports when none have previously been prepared or additional experts' reports if appropriate under the circumstances. Reports protected by an evidentiary privilege may be submitted in a sealed condition to be reviewed only by the Court in camera, with notice of such submission to all parties.

L.R. 202(b)(2). Further, if the minor or incompetent is represented by an attorney, the following must be disclosed:

> the terms under which the attorney was employed; whether the attorney became involved in the application at the instance of the party against whom the causes of action are asserted, directly or indirectly; whether the attorney stands in any relationship to that party; and whether the attorney has received or expects to receive any compensation, from whom, and the amount.

L.R. 202(c).

A court's scope of review is limited to "whether the net amount distributed to each minor plaintiff in the settlement is fair and reasonable, in light of the facts of the case, the minor's specific claim, and recovery in similar cases." *Robidoux,* 638 F. 3d at 1181-82. An assessment of the settlement is performed "without regard to the proportion of the total settlement value designated for adult co-plaintiffs or plaintiffs' counsel – whose interests the district court has no special duty to safeguard." *Id.* at 1182 (citations omitted).

Notably, the holding of *Robidoux* was "limited to cases involving the settlement of a minor's federal claims," and the Circuit did "not express a view on the proper approach for a federal court to use when sitting in diversity and approving the settlement of a minor's state law claims." 638 F.3d at 1179 n.2. However, district courts have extended the application to state law claims. *See Calderon v. United States*, 2020 WL 3293066, at *3 (E.D. Cal. June 18, 2020) (noting that although *Robidoux* "expressly limited its holding to cases involving settlement of a minor's federal claims ... district courts also have applied this rule in the context of a minor's state law claims.") (collecting cases).

ANALYSIS

D.C. is a male disabled adult born on September 18, 2002 and residing in Modesto located within County of Stanislaus, California. (Doc. No. 1-1 at 1). D.C. is a special education

student with exceptional needs within the meaning of that term under California Education Code § 56026. (Doc. No. 1 at 2). D.C. is an individual with mental impairments that substantially limit many major life activities within the meaning of 34 C.F.R. § 104.3(j). (*Id.*). Defendant Modesto City Schools is a public entity duly incorporated and operating under California law as a school district; and is a recipient of federal financial assistance subject to the requirements of Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973. (*Id.*). Defendant Stanislaus County Office of Education is a public entity duly incorporated and operating under California law as a local educational agency; and is a recipient of federal financial assistance subject to the requirements of Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973. (*Id.* ay 2-3).

Local Rule 202

***3** The Court incorporates the alleged facts as set forth in the Complaint, which allegations clearly come with the purview of Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101, *et seq.* and violation of Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, *et seq.* and 20 U.S.C. § 1415. (Doc. No. 1-1). The gravamen of the Complaint is that Defendants' alleged failure to provide D.C. with numerous educational services in 2019-2021 caused D.C. to suffer severe academic deficiencies and consequences to his mental health disorders, including PTSD, depression, separation anxiety, ADHD and conduct disorder, resulting in D.C. becoming homeless and eventually incarcerated. (*See generally id.*). Thus, the Court applies the *Robidoux* standard in its review of the Agreement. *See, e.g.*, *Est. of Sauceda v. City of N. Las Vegas*, 2020 WL 1982288, at *3 n.3 (D. Nev. Apr. 15, 2020) ("The Ninth Circuit has made clear that its standards apply in federal question cases."). The Court finds the Petition, and supporting documents, satisfy Local Rule 202(b)(1). (Doc. No. 1, 1-1).

The Petition also addresses the requirements of Local Rule 202(c), concerning disclosure of the attorneys' interest. (Doc. No. 1-3). Specifically, counsel for Plaintiff, Daniel Shaw, declares that: he was retained by DeNeice Murphy, education rights holder for D.C., to represent D.C., her incompetent son, in connection with D.C.'s educational claims. (*Id.*, ¶3). Counsel neither became involved in the case at the insistence of either Defendant, nor does he have any relationship with either Defendant. (*Id.*, ¶¶ 5-6). Further, as discussed in greater detail below, due to the fee shifting provisions appliable in these cases, Counsel took the case on a contingent basis. Counsel proffers that while the agreed upon fee does not cover the total fees and costs to date, he has elected to take a lesser amount and any remaining fees or costs will not be the responsibility of D.C. or his mother. (*Id.*, ¶¶4, 7). The Court finds the Petition satisfies the requirements of the Local Rule 202(c).

Settlement

The Court now turns to determine whether the amount of the net settlement to the incompetent adult is fair and reasonable and finds, for the reasons explained below, that the "net amount distributed to [D.C.] in the settlement is fair and reasonable, in light of the facts of the case, the [D.C.'s] specific claim, and recovery in similar cases." *Robidoux*, 638 F.3d at 1181-82. Once approved, the Agreement will fully, finally, and forever settle any and all known and unknown claims, rights, demands, or causes of action between D.C. and Defendants that were raised or could have been raised up to the date this Court approves the Agreement. (Doc. No. 1-2 at 4-5, ¶¶ 3-4(a), (b)(c)). The Parties have executed the Agreement. (*Id.* at 7-9).

Defendants will pay the sum of one hundred and twenty-five thousand dollars ($125,000.00), to Plaintiff's Counsel's client trust account. (Doc. No. 1 at 5:4-10). Plaintiff's Counsel will then retain an estate planning attorney and use a portion of the settlement amount to establish a special needs trust, which will cost an estimated six thousand dollars ($6,000.00). (*Id.*).

Defendants will pay Plaintiff's Counsel's firm, Snyder & Shaw, LLP, forty nine thousand dollars ($49,0000.00) for reasonable attorneys' fees and costs in this matter. (*Id.* at 5:11-15). Plaintiff will not be responsible for any further fees or costs. (*Id.*).

Special Needs Trust

The Parties proffer that the Agreement provides for immediate cash payments to D.C. through a special needs trust under 42 U.S.C. § 1396p(d)(4)(A) and California Probate Code § 3600, *et seq.* (*Id.* at 5:17-19). California Probate Code § 3604(b) provides that a special needs trust may be established only if the Court determines all the following:

> (1) [t]hat the minor or person with a disability has a disability that substantially impairs the individual's ability to provide for the individual's own care or custody and constitutes a substantial handicap;

***4** (2) [t]hat the minor or person with a disability is likely to have special needs that will not be met without the trust; and

(3) [t]hat money to be paid to the trust does not exceed the amount that appears reasonably necessary to meet the special needs of the minor or person with a disability.

Cal. Prob. Code § 3604(b)(1)-(3).

The parties submit the requirement of Section (b)(1) is met because D.C. is a disabled and severely mentally ill adult special education student, whose disabilities substantially limits him in a variety of major life activities, including his ability to think, read, socialize, and perform activities of daily living. D.C. was previously homeless and became incarcerated. On September 19, 2022, the Stanislaus Superior Court determined D.C. was incompetent to stand trial. (Doc. No. 1 at 6, ¶3).

As to Section (b)(2), the parties submit D.C. is likely to have special needs that will not be met without the special needs trust. Placement of funds in a special needs trust will ensure D.C. remains eligible for public assistance programs, which benefits are vital to D.C.'s continued support, safety, and personal well-being. Additionally, these essential needs include personal care assistance, in-home supports, independent living services, medical services, and other palliative care, none of which would be met or available without the protection offered by a special needs trust. (*Id.*, ¶4).

As to Section (b)(3), the parties submit that the money to be paid to the trust does not exceed the amount that appears to be reasonably necessary to meet the special needs of D.C. (*Id.*, ¶5).

The Court finds the parties have met the requirements for the establishment of a special needs trust pursuant to California Probate Code § 3604(b).[3]

Settlement Amount and Outcomes in Similar Cases

The parties proffer that the net recoveries to D.C. through the special needs trust will be substantial, and more than sufficient to cover the costs of care for D.C. and to provide the compensatory services he requires because of the educational deficiencies resulting in the alleged incidents described in the Complaint. (Doc. No. 1 at 10). The Parties explain the Agreement allows D.C.'s mother to use funds from the trust for the purposes of providing the compensatory support and services he requires. (*Id.* at 10-11). Plaintiff's counsel believes the settlement is "fair and reasonable," and Defendants dispute causation of D.C.'s injuries and damages. (*Id.* at 11). The parties do not claim that D.C. suffered any physical injuries.

As support, the parties refer the Court to settlements that are in line with or less than the recovery here. (Doc. No. 1 at 9-10). Specifically, the parties direct the Court to *C.F. v. San Lorenzo Unified Sch. Dist.*, 2016 WL 4521857, at *2 (N.D. Cal. Aug. 29, 2016). In *C.F.*, plaintiff initiated claims arising under the Individuals with Disabilities Education Act after the school district deemed C.F. ineligible to receive special education services after C.F's parent had requested that the district perform special education testing before C.F. started kindergarten. Although the district complied with testing, it concluded C.F. was ineligible to receive special education services. While the action was pending, the district reevaluated C.F. and concluded C.F. was eligible to receive special education. The court approved a total settlement in the amount of $65,000, with $10,000 of the total fund going to provide C.F. with educational services, and $55,000 in attorney fees. The court noted "the primary goal of this action was to ensure C.F. received the special education services he needs. The district has agreed to provide those services and to compensate C.F. for any educational opportunities he lost while this litigation was ongoing." *Id.*

***5** In *A.A.*, the court approved a settlement where $63,200 would be deposited into a special needs trust, and an additional $10,000 in settlement funds would be dedicated to trust administration, with the $63,200 "earmarked for a FAPE buyout, i.e., to provide A.A., Jr. with a free and appropriate education through the 2020–2021 school year, at which time his eligibility for services under the IDEA comes to an end." *A.A. on behalf of A.A. v. Clovis Unified Sch. Dist.*, 2018 WL 1167927, at *3-4 (E.D. Cal. Mar. 6, 2018), *report and recommendation adopted sub nom.*, 2018 WL 1453243 (E.D. Cal. Mar. 23, 2018).

In *G.C.*, plaintiff sought implementation of G.C.'s IEP and compensatory education due to the defendant's failure to implement G.C.'s IEP during distance learning over the 2019–20 and 2020–21 school years. The court approved a settlement under the terms of which defendant would provide plaintiff with a total of $108,500 to encompass any future FAPE obligations through June 30, 2021, which is when G.C.

would age out of eligibility for special education and related services. After attorney fees and costs, plaintiff would receive $89,000. *G.C. By & Through Clark v. San Diego Unified Sch. Dist.*, 2021 WL 3630112, at *2–3 (S.D. Cal. Aug. 17, 2021), *report and recommendation adopted sub nom*. 2021 WL 4060534 (S.D. Cal. Sept. 3, 2021).

In *D.C. ex rel. T.C. v. Oakdale Joint Unified Sch*. Dist., No. 1:11-CV-01112-SAB, 2013 WL 275271, at *2 (E.D. Cal. Jan. 23, 2013), plaintiffs alleged that the school failed to provide proper programs, services and activities to D.C. to accommodate his disability—attention deficit hyperactivity disorder and specific learning disability— and alleged that the school improperly used restraints on D.C. on multiple occasions, including one occasion where D.C. sprained his ankle and received medical treatment. The court approved a settlement in total amount of $65,000.00, with $30,000.00 to be disbursed to D.C. (held in a Uniform Minor's Account, with T.C. as custodian), $18,379.00 to T.C., $6,689.50 to legal fees, $6,689.50 to other legal fees, and $3,242.00 to Medi–Cal to satisfy potential liens related to D.C.'s medical treatment.

The Court finds these cases provide support for finding the Agreement fair and reasonable. The Court additionally has conducted its own research and found cases that similarly provides support for finding the Settlement Agreement to be fair and reasonable. *T.L. By and Through Layne v. Southern Kern Unified Sch. Dist.*, 2019 WL 3072583 (E.D. Cal. July 15, 2019), *report and recommendation adopted,* 2019 WL 3459151 (E.D. Cal. July 31, 2019) (court approved settlement under which minor was awarded $24,750.00 based on allegations that the district did not comply with IDEA requirements when removing T.L. form his regular home school); *R.Q. v. Tehachapi Unified Sch. Dist.*, 2020 WL 5940168 (E.D. Cal. Oct. 7, 2020), *report and recommendation adopted,* 2020 WL 6318223 (E.D. Cal. Oct. 28, 2020) (court approved settlement under which school district paid a total amount of $34,000.00 based on allegations that "the refusal to draft a Behavior Intervention Plan to address the [minor's] behavior[ ] interfered with his ability to access his education.").

Attorney's Fees

Generally, attorney's fees in the amount of twenty-five percent (25%) are the typical benchmark in contingency cases for minors. *McCue v. S. Fork Union Sch. Dist.*, No. 1:10-CV-00233-LJO, 2012 WL 2995666, at *2 (E.D. Cal. July 23, 2012) ("It has been the practice in the Eastern District of California to consider 25% of the recovery as the benchmark for attorney fees in contingency cases for minors, subject to a showing of good cause to exceed that rate.").

***6** In light of *Robidoux's* precedent, it may be error for this court to reject the settlement simply because the Court finds that the attorney fees sought are excessive. *See Velez v. Bakken*, 2019 WL 358703, at *2 n.4 (E.D. Cal. Jan. 29, 2019) (noting *Robidoux* makes a reduction of fees simply for finding them to be excessive error, finding attorneys' fees amounting to 46% of the settlement, though higher than benchmark, was "not excessive because of counsel's experience with similar cases, the amount of time counsel spent investigating the claims, and the risk counsel took in pursuing this action on a contingency basis."). Plaintiff's counsel states that he is accepting $49,000 as full payment in this matter. Despite his fees and costs being more than this amount, counsel states that Plaintiff will not be responsible for any additional fee. (Doc. No. 1-3, ¶7). In consideration of the course of litigation, the facts of the case, and the total settlement amount, the Court does not find the attorney's fees excessive.

ACCORDINGLY, it is hereby **ORDERED:**

1. Joint Petition for Approval of Incompetent's Compromise (Doc. No. 1) is GRANTED.

2. Within in thirty days of the date of this Order, the Defendant's will issue a check in the amount of $125,000.00 to be deposited into Snyder & Shaw LLP's client trust account.

3. Snyder & Shaw LLP will use a portion of the settlement funds to pay an estate planning attorney to setup a special needs trust. Once the trust is established, Snyder & Shaw LLP will deposit the remaining funds in the special needs trust.

4. Additionally, the Defendants will pay a total amount of forty-nine thousand dollars ($49,000.00) for reasonable attorney's fees and costs to Snyder & Shaw LLP incurred because of the OAH administrative proceeding and threatened civil claims.

5. This Court will retain jurisdiction over the enforcement of the Settlement Agreement.

6. The Clerk shall terminate the pending motion (Doc. No. 11) on the docket and CLOSE this case.

All Citations

Slip Copy, 2023 WL 6060044

Footnotes

1 Both parties have consented to the jurisdiction of a magistrate judge in accordance with 28 U.S.C. § 636(c)(1). (Doc. No. 10).

2 While various quotations from cited materials herein use the term “minor,” the Court considers any such citations or discussion to be applicable to the settlement of the incompetent Plaintiff's claims consistent with the use of “minor” and “incompetent” in both Fed. R. Civ. P. 17(c) and L.R. 202.

3 The Parties further submit that the special needs trust will “fully comply” with California Rule of Court, Rule 7.903. (Doc. No. 1 at 6, ¶6).

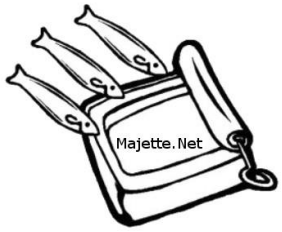
Citing References (20)

Title	Date	NOD Topics	Type
1. Lamle by and through Lamle v. Shropshire 2024 WL 2754048, *1 , W.D.Okla. Medicaid is a federal program implemented by participating states. See 42 U.S.C. § 1396 et seq. It was created to provide medical care to people “whose income and resources are...	May 29, 2024	—	Case
2. Agency for Health Care Administration v. Spence --- So.3d ----+ , Fla.App. 3 Dist. ESTATE PLANNING AND PROBATE — Trusts. Terms of special needs trust were clear and unambiguous, including payback provision.	May 22, 2024	—	Case
3. Matter of Guardianship of Hindman 2024 WL 2197220, *6 , Tex.App.-Corpus Christi Appellee Virginia Hindman was appointed by the trial court as guardian of the person and estate of Robert Lewis Hindman, her husband. Subsequent to Virginia's appointment,...	May 16, 2024	—	Case
4. Wiedner v. Stevenson 2024 WL 2125657, *10 , Cal.App. 2 Dist. Before her death, Roberta Louise Davis established a special needs trust—within her own inter vivos trust—to benefit her gravely disabled adult son Daniel L. Black during his...	May 13, 2024	—	Case
5. Story v. Carbone 2024 WL 2150288, *3+ , Conn.Super. This matter, tried to the court, presently comes before the court on the Defendant's Motion for Directed Verdict and/or Post-trial Brief and the Plaintiff's Post-trial Memorandum....	May 10, 2024	—	Case
6. Texas Health and Human Services Commission v. Estate of Burt 689 S.W.3d 274, 282+ , Tex. HEALTH — Medical Assistance. Under the plain language of statute excluding a Medicaid applicant's home when determining resources for purposes of eligibility for Medicaid benefits,...	May 03, 2024	—	Case
7. Hammerberg as trustee for Leonard J. and Margaret T. Schubert Irrevocable Trust, dated June 23, 2005 v. Minnesota Department of Human Services 2024 WL 1712748, *2+ , Minn.App. Appellant Minnesota Department of Human Services (DHS) challenges a district court order reversing a DHS decision that real property held in a trust was subject to a lien under...	Apr. 22, 2024	—	Case
8. Department of Health and Welfare v. Beason 546 P.3d 684, 688+ , Idaho HEALTH — Medical Assistance. Four-year catch-all statute of limitation applied to Department of Health and Welfare action to set aside property transfer by Medicaid recipients.	Apr. 11, 2024	—	Case
9. In re Marriage of Moriarty --- N.E.3d ---- , Ill.App. 1 Dist. FAMILY LAW — Child Support. Mother's petition for adult disabled child support under Marriage and Dissolution of Marriage Act for adult child diagnosed with autism spectrum...	Mar. 29, 2024	—	Case

Title	Date	NOD Topics	Type
10. Cavanaugh v. Geballe 2024 WL 1050325, *1+ , D.Conn. Plaintiff Brian Cavanaugh commenced this § 1983 action against Defendant Josh Geballe in his individual capacity and his official capacity as the Commissioner of the Department of...	Mar. 11, 2024	—	Case
11. Matter of Ellen H. 205 N.Y.S.3d 920, 920 , N.Y.Sup. This decision and order issues on a petition filed on October 11, 2023 by Mental Hygiene Legal Service (3rd Dept.) (“MHLS”), Jordan Charnetsky, Esq., of counsel. The petition asks...	Mar. 05, 2024	—	Case
12. Bell v. United States 169 Fed.Cl. 466, 480 , Fed.Cl. TAXATION — Refunds. Taxpayer who was “nonresident alien,” as defined by Tax Code, was not entitled to refund since value of his deduction for personal exemption was zero.	Jan. 25, 2024	—	Case
13. Matter of Estate of Abad 540 P.3d 244, 245+ , Alaska HEALTH — Medical Assistance. Medicaid reimbursement claims by State against recipient's estate arise before, not after, recipient's death for purposes of filing deadline.	Dec. 22, 2023	—	Case
14. Matter of Estate of Mason 222 N.E.3d 1082, 1084+ , Mass. HEALTH — Medical Assistance. Medicaid administrator could not enforce lien on recipient's real property after her death in residential facility.	Dec. 13, 2023	—	Case
15. In re Estate of Ecklund 998 N.W.2d 308, 312 , Minn.App. ESTATE PLANNING AND PROBATE — Claims. County was entitled, under estate-recovery statute, to recover costs of enumerated long-term-care services actually provided.	Nov. 20, 2023	—	Case
16. H.L. v. Division of Medical Assistance and Health Services 2023 WL 7985532, *4 , N.J.Super.A.D. H.L. appeals from the January 25, 2022 final agency decision of the Division of Medical Assistance and Health Services (“Division”) upholding the transfer penalty on H.L.’s receipt...	Nov. 16, 2023	—	Case
17. Hegadorn v. Livingston County Department of Health and Human Services --- N.W.2d ----+ , Mich.App. HEALTH — Medical Assistance. Fact that wife had assets available to her at time of initial assessment was not conclusive of assets available for purposes of Medicaid eligibility.	Oct. 19, 2023	—	Case
18. Harves by Harves v. Rusyniak 219 N.E.3d 166, 170+ , Ind.App. HEALTH — Medical Assistance. Before corpus of irrevocable trust can be “available resources,” it must be possible for payment from trust to be made to applicant.	Sep. 26, 2023	—	Case
19. Doan v. Kijakazi 2023 WL 6215794, *1+ , E.D.Cal. Plaintiff seeks judicial review of a final decision of the Commissioner of Social Security (“Commissioner”) finding that she was ineligible to receive Supplemental Security...	Sep. 25, 2023	—	Case

Title	Date	NOD Topics	Type
20. **D.C. by and through Murphy v. Modesto City Schools** 2023 WL 6060044, *3 , E.D.Cal. Before the Court is a Joint Petition for Approval of Incompetent's Compromise filed by the minor Plaintiff D.C., by and through his guardian ad litem, DeNeice Murphy (“Plaintiff”)...	Sep. 18, 2023	—	Case

Virginia Long Term Care Medicaid Planning Highlights
Citations to The Virginia Medicaid Manual Through Transmittal #DMAS-27 (Effective 4-1-2024)[1]



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https://majette-my.sharepoint.com/personal/shawn_majette_net/Documents/2024 Medicaid Planning Highlights with triple scoop trust 8 16 1409.docx 9/3/2024 12:18 PM

As of September 3, 2024[4]

[1] Medicaid Manual hyperlinks in this work are a work in progress as of August 16, 2024.

Until updated, links will invoke the writer's 2022 Medicaid Manual.

The writer's Virginia Medicaid Manual assimilation, *effective July, 2024,* has been posted at Majette.net (click).

Readers in previous iterations reported that iOS and some versions of Windows link only to the first page of the 1,816 page assimilation. Should aught befall you, hover the mouse over the hyperlink and jot down the numerals after the "=" in the link, and direct your .pdf reader to that page in the Medicaid Manual Assimilation.

For example, the link to the SSI and related limits at Section I.D. below (~line 36) CMS link is the following:

https://majette.net/wp-content/uploads/2024/08/MedMan81224_Bates.pdf#page=1816

The transmittal commences at sequential ("Bates") page 1,816.

Reader, please assure timeliness of content.

[2] Retirement takes more time than the writer knew. The deadline was met in the initial submission but even this late tweak creaks and rattles. The oil can at the ready, the writer covets the reader's reports. In the meantime, thanks to all my friends in the Virginia Law Foundation, and the Virginia Bar, Bench, Universities, and beyond - for a wondrous life. In half a tick will I hear a bell, Clarence?

[3] The writer especially acknowledges with gratitude the observations and corrections of friends and former colleagues at Thompson McMullan, P.C., the Virginia Academy of Elder Law Attorneys, the Special Needs Alliance, and mostly, Mrs. Majette. Errors are the writer's; *kudos* and boundless appreciation belong to them for tolerance and corrections.

The soundtrack for this work, "*Ragtime in the Air,"* is from the 1913 Broadway Musical, "*America*." This version was recorded ~ 1913 by Billy Murray. Mr. Murray, born William Thomas Murray in Philadelphia, died in the year of the writer's birth, and was likely entertained by Houdini and others instructed by Harlan Tarbell. Mr. Tarbell is the polymath *auteur* of the footer graphic (a magician with handkerchief) in his peerless *Tarbell's Magic Course*. Mr. Tarbell wrote and illustrated the work; the writer wished he did.

The writer believes that the intellectual property in Mr. Murray's and Mr. Tabell's art are treasures of the public domain. Clarence the Angel (footnote 2) is in the domain (and our hearts) forever, viz.

[4] Dates and date specific data are highlighted as an aid to the reader. These data change throughout the year. **Be diligent in assuring data accuracy at the time of use**.

LS September 3, 2024 12:18:00 PM

I. Effective Dates of Limits and Standards in this Outline; Acknowledgements.

A. The present work incorporates limits / standards published in the Virginia Department of Social Services Policy **Transmittal #DMAS-32** (July 1, 2024), amending the Virginia Medicaid Manual, effective for that date. The SSI amounts, ABD deeming standard amount, ABD student child earned income exclusion, CBC personal maintenance allowance, spousal resource standard, spousal resource maximum, maximum monthly maintenance needs allowance, Medicare premiums, etc., for 2024 included through this outline are effective as of the publication date. When not provided in the Virginia Medicaid Manual, they were gathered from reliable sources.[5]

B. The Income Limits for aged, blind and disabled persons as of the date of this work are stated at Medicaid Manual § M 0810.002.

C. FAMIS income limits are most easily accessed through the FAMIS Cover Virginia.

D. Social Security Administration Supplemental Security Income (SSI) for 2024.[7]

E. Remember the continuing Gift of the MAGI.

1. Medicaid expansion benefits, a powerful blessing to many in the time of COVID, remain an available lifeline to low income Virginians.
2. MAGI is the technical name of the program, effective January, 2019.[8]
3. It is available to persons who are between the ages of 19 and 65, not eligible to receive Medicare, whose income is no more than 133% of the FPL plus a 5% income disregard, and who are not eligible in a Medicaid mandatory covered group or covered by the Breast And Cervical Cancer Prevention And Treatment Act.[9]

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[5] Medicare Advocacy's Medicare Summaries; CMS' Medicare & You; CMS' Federal-Policy-Guidance; SSI and Spousal Impoverishment Standards described in the CMS letter and linked table. The table is reproduced as Exhibit A of this outline. It contains the SSI and Medicaid "community spouse" (explained below) allowances effective until the first day of January or the first day of July following the date of this outline.

[7] The present Supplemental Security Income (SSI) income level (payment amount) is $943 for an individual and $1,371 for a married couple. See Exhibit A to this work and the last page of the assimilated manual.

[8] Va. Medicaid Manual M 330.250.

[9] Va. Medicaid Manual M04 Modified Adjusted Gross Income (MAGI) Appendix 7 states the limits for 2024. 133% of the Federal Poverty Level for 2024 for a single person is $20,029 year / $1,670 month. Including the 5% disregard (138%), the ***actual*** limit amount is $20,360 year / $1,733.

4. There is no ***general*** resource test, but the home equity limitations and transfer of assets tests apply.[10]
5. All persons under 65 without substantial incomes (including persons who are disabled but not Social Security Administration *certified* as disabled, and eligible for Medicare), and especially those who have recovered substantial personal injury or worker compensation recoveries, should consider a non-payback trust described below.

F. A New Dawn: Lawyers and *Loper Bright*.[11]

1. "The Administrative Procedure Act requires courts to exercise their independent judgment in deciding whether an agency has acted within its statutory authority, and courts may not defer to an agency interpretation of the law simply because a statute is ambiguous; *Chevron* is overruled."[12]

   "*Chevron* is overruled. Courts must exercise their independent judgment in deciding whether an agency has acted within its statutory authority, as the APA requires. Careful attention to the judgment of the Executive Branch may help inform that inquiry. And when a particular statute delegates authority to an agency consistent with constitutional limits, courts must respect the delegation, while ensuring that the agency acts within it. But **courts need not and under the APA *may not* defer to an agency interpretation of the law simply because a statute is ambiguous.**"

2. *Automatic* deference to the edicts of Department of Medical Assistance Services and to the Social Security Administration is no longer tolerated in cases in which federal rights and statutes (Medicaid among them) are material. The pronouncements rise and fall on their own merits, as those merits are determined by a judge. Experts will be the stones in our slings.

3. As of August 22, 2024, Fastcase reports that 132 cases cite *Loper Bright*.[13]

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[10] *"Although no resource test is applicable for MAGI Adults coverage, the worker must evaluate certain resources for any individuals seeking Medicaid payment for LTSS. These include asset transfers, trusts, annuities, and the home equity limit. See M1410.050*." Emphasis in original. Va. Medicaid Manual §§ M 1460.207 (LTSS), 0330.250 (all others).

[11] *Loper Bright Enterprises v. Raimondo and Relentless, Inc. v. Department of Commerce*, 603 U.S. ___(June 28, 2024). See Amy Howe, *Supreme Court strikes down Chevron, curtailing power of federal agencies*, SCOTUSblog (Jun. 28, 2024, 12:37 PM), https://www.scotusblog.com/2024/06/supreme-court-strikes-down-chevron-curtailing-power-of-federal-agencies/

[12] Syllabus.

[13] Each member of the Virginia State Bar has access to Fastcase through the auspices of the Bar. Technician Cara reported that Fastcase does not support a batch or case listing command. An analysis is beyond the scope of this work, but *Ard v. O'Malley*, 21-2422 (4th Cir. Aug 01, 2024), is the only 4th Circuit Case applying *Loper Bright* presently reported.

II. The Six Medicaid Tests For An Institutionalized Spouse Of A Non Institutionalized Spouse.

A. Your Papers, Please: Citizenship and Identity Credentials for Non-Medicare / SSI enrollees.

1. Individuals presently entitled to or enrolled in Medicare, individuals receiving Social Security benefits on the basis of a disability and SSI recipients currently entitled to SSI payments are exempt from the citizenship requirement.[14]

2. For nonexempt individuals, "Improved Enforcement of Documentation Requirements," requires submission of documentary proof of citizenship and identity with a Medicaid application.[15]

3. Virginia Medicaid policy accordingly requires proof of identity and citizenship for new applications and re-certifications for non-exempt individuals.[16]

   a. When a Medicaid application includes an unsupported allegation of citizenship, the Virginia Department of Medical Assistance Services must extend a "reasonable opportunity" to provide the documentation.[17]

      i. Upon application, if an individual meets all other Medicaid eligibility requirements and declares that he is a citizen, the individual is to be enrolled, giving him the reasonable opportunity period to provide citizenship and identity verification.

      ii. The individual remains eligible for Medicaid during the reasonable opportunity period.

At issue was one test for Miss Ard, who was denied disability in part because she was not 50 years of age. She was "six months and seventeen days away from her fiftieth birthday...." Ard v. O"Malley, 21-2422 (4th Cir. Aug 01, 2024). At issue was whether she was "nearly" 50. The Court considered the Social Security Administration POMS in the light of precedent but without according it deference, citing *Loper Bright*.

[14] "Individuals entitled to or enrolled in Medicare, individuals receiving Social Security benefits on the basis of a disability and SSI recipients currently entitled to SSI payments. ***Former SSI recipients are not included in the exemption***. The local department of social services (LDSS) must have verification from the Social Security Administration (such as a SVES response) of an individual's Medicare enrollment, benefits entitlement or current SSI recipient status." Va. Medicaid Manual § M 0220.100 C 2. The exemption also applies to foster care children and those born to Medicaid eligible mothers.

[15] The provision amends 42 U.S.C. 1396b.

[16] Va. Medicaid Manual § M 0220.100 C 1.

[17] Va. Medicaid Manual § M 0220.100 C 4. While the Manual states there is a "Reasonable Opportunity Insert" hyperlink form to be provided in notices questioning citizenship and identity, the same was not available as of 8-20-2024.

iii. The reasonable opportunity period extends from the date of application to the one year annual review.[18]

4. Sources of proof of citizenship and identity are set out in various parts of the Virginia Medicaid Manual with links to forms, etc.[19]

B. Age or Disability.

1. Except for MAGI eligible persons in long term care (about 37%),[20] the applicant must be 65 or, if younger, disabled for purposes of the Social Security Administration.[21]

C. Prescreening: Activities of Daily Living / U.A.I.[22], §M[23]1420.100[24]

1. Prescreening is required for persons entering long term care, PACE, or community based care[25] except for "special circumstances."[26]

2. The prescreening assesses the institutionalized spouse's ability to perform activities of daily living by reference to a standardized testing survey, the Uniform Assessment Instrument.

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[18] *Id.*, C 4.

[19] Va. Medicaid Manual § M 0220, Appendices 6 and 7.

[20] "Most but not all persons in need of long-term care are elderly. Approximately 63% are persons aged 65 and older (6.3 million); the remaining 37% are 64 years of age and younger (3.7 million)." ☜

[21] Va. Medicaid Manual § M 0310.001. LTSS, Va. Medicaid Manual §M 1460.200 (LTC).

[22] Virginia's Uniform Assessment Instrument (U.A.I.), the Manual for its use, and related forms search page are located at this link, http://majette.net/assessment-instruments.

[23] All cites to "§M" or "§S" are current citations to the Va. Medicaid Manual, accessed as noted above, via http://majette.net, and directly at the official Virginia site.

[24] January, 2024 update.

[25] "*In order to qualify for nursing facility care, an individual must be determined to meet functional criteria, have a medical or nursing need and be at risk of nursing facility or hospital placement within 30 days without services. An assessment known as the LTSS Screening is completed by a designated screener. For individuals who apply for Medicaid after entering a nursing facility, medical staff at facilities document the level of care needed using the Minimum Data Survey (MDS). The Eligibility Worker does not need to see any screening authorization if the individual applying is already a resident of a nursing facility when the Medicaid application is filed*." Va. Medicaid Manual § M 1420.200 (B). (*Emphasis* in original.)

[26] Va. Medicaid Manual § M 1420.400 "*Screening for LTSS is NOT required when the individual is a resident in a nursing facility, receiving CCC Plus Waiver services or in PACE at the time of application and was admitted to the service prior to July 1, 2019; the individual resides out of state (either in a community, hospital or nursing facility setting) and seeks direct admission to a nursing facility; the individual is an inpatient at an in-state owned/operated facility licensed by DBHDS, in-state or out of state Veterans hospital, military hospital or VA Medical Center, and seeks direct admission to a nursing facility; the individual enters a nursing facility directly from the CCC Plus Waiver or PACE services; the individual is being enrolled in Medicaid hospice*." *(Emphasis in original.)*

3. There is a special and separate "Waiver Management System (*WaMS*) Screen Print for Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waiver Authorizations" to screen for these programs.[27]

4. Screening is generally performed by DMAS authorized local teams or by staff at the acute care facility from which an admission is being made.[28]

   a. Patients placed directly from acute care hospitals are usually screened by hospital screening team**s**. Generally, hospitals contract with DMAS to establish pre-admission screening committees to perform the screening process internally.

   b. A state level **c**ommittee is used for patients being discharged from State Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) institutions for the treatment of mental illness, and mental retardation.

   c. Patients in a Veterans Administration Medical Center (VAMC) who are applying to enter a nursing facility are assessed by VAMC staff. VAMC discharge planning staff use their own Veterans' Administration assessment form, which serves as the pre-admission screening certification.

   d. Different screening teams may be required for various waiver programs.[29]

5. The screening criteria are ongoing, and DMAS can rescind certification while the recipient remains in the nursing home.[30]

6. The "Medicaid Funded Long Term Services and Supports Authorization Form" is a required form for long term care (nursing home and other) payments.[31]

D. Monthly Income.

1. Unmarried Institutionalized Applicants / Recipients.

   a. When income of applicant / recipient under $2,829 (in **2024**),[33] automatic income eligibility.[34]

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[27] Va. Medicaid Manual § M 1420, Appendix 1. Note Olive's (mis-spelled) name, establishing that somebody at DMAS has a remarkable sense of humor and shares the writer's admiration for the Fleischer Brothers.

[28] Va. Medicaid Manual §M 1420.200 B.

[29] *Id.* C.

[30] Va. Medicaid Manual §M 1420.100 B 4. "Facilities document the level of care using the Minimum Data Survey (MDS). For an individual in a nursing facility who no longer meets the level of care but continues to reside in the facility, continue to use the eligibility rules for institutional individuals even though the individual no longer meets the level of care criteria. Medicaid will not make a payment to the facility for LTSS."

[31] Va. Medicaid Manual § M 1420.100 (B).

[33] Va. Medicaid Manual §M 0810.002 A 3.

[34] The figure is 300% of the present SSI level for one person. Such persons categorically meet the test for long term care if

b. When Income of applicant / recipient exceeds 300% of the SSI income level, income eligibility depends upon the specific facility Medicaid rate:[35]

1. **Spenddown Liability Less Than or Equal to Facility Medicaid Rate** If the spenddown liability is less than or equal to the facility's Medicaid rate, determine spenddown eligibility by projecting facility costs at the Medicaid rate for the month. Spenddown balance after deducting projected costs at the Medicaid rate should be zero or less. The patient is eligible as MN for the whole month.

2. **Spenddown Liability More Than Facility Medicaid Rate** When the spenddown liability is **more than** the facility Medicaid rate, determine spenddown eligibility AFTER the month has passed, on a daily basis (do not project expenses) by chronologically deducting old bills and carry-over expenses, then deducting the facility daily cost at the **private** daily rate and other medical expenses as they were incurred. If the spenddown is met on any date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month. Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed.

2. Married Applicants / Recipients.[36]

a. ***ONLY*** income of institutionalized adult is counted.[37]

b. When an institutionalized person is married to a spouse who is not institutionalized, the institutionalized spouse is an "institutionalized spouse" (the "IS") under special rules.

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they also meet the other Medicaid tests. Va. Medicaid Manual §M 1460.200 B 3; 1460.400 D 3. MAGI recipients are covered without a spenddown liability. Va. Medicaid Manual §M 1460.207.

[35] Va. Medicaid Manual § M 0810.002 (generally); M1460.410 C 4 (for facility resident), C 5 for CBC waiver service costs. For CBS waiver services, "[e]ligibility is evaluated on a monthly basis. Determine spenddown eligibility AFTER the month has passed, by deducting old bills and carry-over expenses first, then (on a daily basis) chronologically deducting the daily CBC cost at the **private** daily rate and other medical expenses **as they are incurred.** If the spenddown balance is met on a date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month. Each month must be evaluated separately. *These patients will always be enrolled after the month being evaluated has passed."* (*Emphasis* in original.)

There are different rules for a facility resident / CBC recipient who is married to a spouse who is neither, see Va. Medicaid Manual § M 1480.300.

[36] Va. Medicaid Manual § M 1480.300, Income Eligibility Of Institutionalized Spouse.

[37] "Do not deem a community spouse's income available to an institutionalized spouse for purposes of determining the institutionalized spouse's Medicaid eligibility for any month of institutionalization (including partial months). For the month of entry into institutionalization and subsequent months, only the institutionalized individual's income is counted for eligibility and patient pay purposes." Va. Medicaid Manual § M 1480.300 B 3, *Income Deeming.*

c. The non-institutionalized spouse is referred to as the community spouse (the "CS").

d. The income of the CS is not considered in determining Medicaid eligibility for the IS.

e. After eligibility of the institutionalized spouse is conferred, income of the IS may be paid to the CS under the rules below.

3. Income of IS under 300% of SSI,[38] automatic eligibility; otherwise, daily, retroactive counting may be required to qualify as a "medically needy" recipient.[39]

4. Supplementing CS Income: The "Minimum Monthly Maintenance Needs Allowance" (MMNA)[40]

a. "Standard" (minimum: $2,555)[41] until the first day of July following the date of this work.

b. Maximum MMNA (including a Monthly Excess Shelter Allowance): $3,853.50 until the first day of January following the date of this work.

The Excess Shelter Standard (or Allowance) is intended to assist a community spouse with qualified housing / utility costs exceeding the "shelter standard," which Congress set at 30% of the community spouse's income allowance.[42] The excess shelter allowance is calculated by subtracting the shelter standard ($766.50[43] until the first day of July following the date of this work) from the sum of these expenses: CS monthly mortgage (PITI) or rent, homeowner association dues, homeowner insurance, and a utility allowance ($414.00 or, with more than 3 in the household, $524.00).[44]

The remainder is added to the MMNA. The total monthly allowance for the CS is capped at the Maximum Excess Shelter Allowance.

[38] $2,829 (in 2024). Va. Medicaid Manual § M 0810.002, see *supra*.

[39] Va. Medicaid Manual § M 0810.002; Va. Medicaid Manual § M 1480.310 B 3; Va. Medicaid Manual §M 1480.300.

[40] Va. Medicaid Manual § M 1480.410.

[41] *Id.*

[42] Medicaid Manual § M 1480.010 (B)(10).

[43] *Id.* The standard is 30% of the Monthly Maintenance Needs Allowance. The shelter standard is set at Va. Medicaid Manual §M 1480.410.

[44] The higher utility allowance applies to households in which more than three persons reside. Va. Medicaid Manual §M 1480.410.

c. Dependent Family Member[45] Allowance. The allowance is calculated by reference to the minimum monthly maintenance needs standard allowance as follows: the community spouse MMNA – the dependent family member's income divided by 3.[46]

5. The income allowance available as a patient-pay deduction to the institutionalized spouse may be increased by a hearing officer upon a showing that "exceptional circumstances resulting in extreme financial duress" require the increase.[47]

6. For ***post-eligibility*** support supplements, the CS may secure a court order for support using familiar domestic relations law, but only *after* having exhausted the Medicaid administrative process.[48] The Commonwealth's domestic relations support law does not require any showing of "extreme financial duress" in determining the support needs of the CS.[49]

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[45] A dependent family member is "a parent, minor child, dependent child, or dependent sibling (including half-brothers/sisters and adopted siblings) of either member of a couple who resides with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes under the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse." Medicaid Manual § M 1480.010 B 8.

[46] Va. Medicaid Manual § M 1480.010 B 11. The example reflects the MMNA in 1999; substitute the current minimum monthly maintenance needs standard from Va. Medicaid Manual § M 1480.410, *supra*.

[47] Va. Medicaid Manual §M 1480.430 D 3. *Cf. Urrutia v. Daines*, 2011 NY Slip Op 9137; 2011 N.Y. App. Div. LEXIS 8961 (Sup.Ct., December 13, 2011)("significant financial distress" from "exceptional circumstances" not demonstrated within meaning of 42 USC § 1396r-5[e][2][B], citing, *inter alia*, *Gomprecht v. Gomprecht*, 86 NY2d 47, 52, 652 N.E.2d 936, 629 N.Y.S.2d 190 (NY Ct. App. 1995).

[48] "The Eligibility Worker [EW] has no flexibility to calculate a minimum monthly maintenance needs allowance greater than the one calculated using the steps listed above. If the individual states there is a need for a greater amount, he has the right to file an appeal using the procedures in chapter M16. A Hearing Officer may increase the community spouse income allowance if it is determined that exceptional circumstances resulting in extreme financial duress exist. If the individual disagrees with the outcome of the appeal, he may then appeal the decision through his local circuit court. The EW cannot accept a court order for a greater community spouse allowance *unless the individual has exhausted the Medicaid administrative appeals process*." Va. Medicaid Manual §M 1480.430 D. 3, emphasis supplied by writer. The writer knows of no Virginia authority to support the quoted limitation, which imposes a significant burden upon the institutionalized spouse to obtain support in obvious contravention of the domestic relations law of Virginia: an unsuccessful administrative appeal through the circuit court level when a negative result is all but assured, in part because the "extreme financial duress" standard does not and has never been relevant in obtaining support from an absence spouse. As to enforceability of the rubber stamp of "agency deference," see Loper Bright discussion *supra*, and writer's case law update for 2024 published by the Virginia Law Foundation CLE program.

[49] Va. Code § 16.1-241 (L). See Va. CLE publication, Virginia Family Law - A Systematic Approach, Balnave, §6.2 (footnote .2). Venue in the Juvenile and Domestic Relations District Court is where either party resides or the defendant is present. Va. Code § 16.1-243 (A)(2) and Rule 8.3(C), Rules of the Virginia Supreme Court, Part Eight, Juvenile and Domestic Relations District Courts. Form DC-610 is the Juvenile and Domestic Relations District Court form for child support. Va. Code § 16.1-278.17:1 provides presumptions for spousal support in cases in which the combined gross income of the spouses does not exceed $10,000 per month. ¶ A provides a presumption of pendente lite support. ¶ C provides the general rule for calculations. ¶ D states that the "court may deviate from the presumptive amount for good cause shown, including any relevant evidence relating to the parties' current financial circumstances or the impact of any tax exemption and any credits resulting from such exemption that indicates the presumptive amount is inappropriate."

There is no requirement that the requesting spouse prove that she is under financial duress, extreme or otherwise.

In the light and sound of Loper Bright, the Virginia General Assembly, the Virginia Administrative Code (12VAC30-110-856, *Revisions to the Community Spouse Resource Allowance)*, and decades of judicial gloss *impel* review.

Va. Code § 20-107.1 (A) provides that the court, "[p]ursuant to any proceeding arising under subsection L of § 16.1-241 or upon the entry of a decree providing (i) for the dissolution of a marriage, (ii) for a divorce, whether from the bond of matrimony or from bed and board, (iii) that neither party is entitled to a divorce, or (iv) for separate maintenance, the court may make such further decree as it shall deem expedient concerning the maintenance and support of the spouse."

12VAC30-110-856 provides that a community spouse resource allowance may be allowed if "[a]n institutionalized spouse transfers resources to a community spouse pursuant to a court order for spousal support." There is no requirement that the community spouse pursue any other course. There is no basis for the unsupported (and inconsistent) manifest of Medicaid policy subordinating the judgment of a Virginia judge to that of a hearing officer directed and controlled of the Department of Medical Assistance Services, sic:

> **Spousal Protected Resource Amount (PRA)** means at the time of Medicaid application as an institutionalized spouse, the greater of:
>
> • the spousal resource standard in effect at the time of application;
>
> • the spousal share, not to exceed the maximum spousal resource standard in effect at the time of application;
>
> • the amount of resources designated by a DMAS Hearing Officer, or
>
> • an amount actually transferred to the community spouse by the institutionalized spouse pursuant to a court spousal support order *issued as the result of an appeal of the DMAS Hearing Officer's decision*.
>
> Va. Medicaid Manual § M 1480.410 B 25.
>
> Revisions to the community spouse's calculated protected resource amount (PRA) can be made when:
>
> 1. A DMAS Hearing Officer determines that the income generated from the resources is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance (MMMNA). Substitute the amount the DMAS Hearing Officer determines for the PRA calculated in section M1480.232 above.
> 2. A DMAS Hearing Officer confirms that the initial PRA determination was incorrect.
> 3. A court orders spousal support in an amount that is greater than the PRA established in subsection B above ***after*** *the applicant completes the administrative appeals process.*
>
> Va. Medicaid Manual § M 1480.232 F. Accord, Va. Medicaid Manual § M1480.232 B 2; Va. Medicaid Manual § M1480.232 D (Hearing officer increased resource allowance based ***only*** on her "extraordinary shelter and medical expenses).
>
> (***Emphasis***(but not highlighting) in original.)

In sharp contrast, Virginia a trial courts have broad discretion to set spousal support based upon what the requesting spouse needs in the balance of the other spouse's ability to pay, and the award will not be overturned on appeal

E. Resources: Exempt and Countable.

1. Exempt and countable resources.

a. What's a resource for Medicaid purposes?

i. It's property, but not every interest in property is a resource.[50]

ii. A resource is any property which a person owns **and which** the person has the right, authority, or power to convert to cash (if not already cash); **and which** is not legally restricted from using for his/her support and maintenance.[51]

b. All resources are countable unless specifically exempted.

c. Otherwise countable resources exempted equal to value of Partnership Long Term Care Insurance Policy payments made at the time of application.[52]

i. The value of assets disregarded in the Medicaid eligibility determination is equal to the dollar amount of benefits paid to or on behalf of the individual as of the month of application, even if additional benefits remain available under the terms of a qualified partnership policy. Interestingly, the resources disregarded by reason of

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except upon abused discretion:

> The trial court has 'broad discretion in setting spousal support and its determination will not be disturbed except for a clear abuse of discretion.'" Wyatt v. Wyatt, 70 Va.App. 716, 719 (2019) (quoting Giraldi v. Giraldi, 64 Va.App. 676, 681 (2015)). "When a court awards spousal support based upon due consideration of the factors enumerated in Code § 20-107.1, as shown by the evidence, its determination 'will not be disturbed except for a clear abuse of discretion.'" Chaney v. Karabaic-Chaney, 71 Va.App. 431, 435 (2020) (quoting Dodge v. Dodge, 2 Va.App. 238, 246 (1986)). "In determining the appropriate amount of spousal support, the trial court must consider the needs of the requesting party and the other spouse's ability to pay." Wyatt, 70 Va.App. at 719 (quoting Alphin v. Alphin, 15 Va.App. 395, 401 (1992)).
>
> *Leo v. Leo*, 1402-22-4 (Va. App. Oct 10, 2023).

Local rules of court should be consulted (available sites for Juvenile and Domestic Relations District Courts with forms and local rule information, see http://www.courts.state.va.us/courts/jdr/home.html). See statutory references, IV., *infra*, to binding effect of post-nuptial settlement agreements in establishing support, Title 20, Chapter 8, Code of Virginia, and especially Virginia Code § 20-155, *Marital agreements*.

[50] Va. Medicaid Manual § S 1110.100 (A). "Not everything an individual owns (assets) are resources for Medicaid purposes. Moreover, in certain situations, an asset that is not a resource may become one at a later date or vice versa. The distinction is important since an asset that is not a resource does not count against the resource limit; and proceeds from the sale or trade of a resource (i.e., the amount representing conversion of principal from one form to another) are also resources but what a person receives from a non-resource [asset] is subject to evaluation as income at the time of receipt."

[51] *Id.* B.

[52] Va. Medicaid Manual § M 1460.160.

such a long term care insurance policy is not applicable to the resource assessment for married individuals with a community spouse.[53]

ii. A long term care insurance policy is a qualified partnership policy only if it meets these conditions:

1. it must be issued on or after 09/01/2007;

2. it much contain a disclosure statement indicating that it meets the requirements under § 7702B(b) of the Internal Revenue Service Code of 1986, and

3. it must provide inflation protection for persons under 76 years of age and under as follows:

A. compound annual inflation protection for persons under 61 years of age; and

B. any level of inflation protection for persons 61 to 76 years of age.[54]

2. Selected Excluded Resources: §M 1130 referenced in chart at §M 110.210 B; 1480.210 B.

a. Home of the institutionalized person.[55]

i. Home is defined as the property which serves as the principal residence.[56]

ii. Married persons when one is institutionalized but the other spouse is resident in the home, and applicants in the 80% FPL category, may exempt *all* real property contiguous to the residence.[57]

iii. The home (including contiguous property of limited value for an unmarried applicant / recipient, or unlimited value when the applicant / recipient has a CS or

[53] *Id.* "The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of an LTC Partnership Policy (Partnership Policy)." Va. Medicaid Manual § M 1480.210 B. Va. Medicaid Manual § M 1480.220 B. In community spouse / institutionalized spouse cases, the resources disregarded by reason of a Partnership Policy is a further deduction from the total countable resources. Va. Medicaid Manual § M 1480.232 B. 3.

[54] Va. Medicaid Manual § M 1460.160 C.

[55] Va. Medicaid Manual § M 1460.530 applies to the home exclusion generally regarding Medicaid applications for long term care benefits. However, it expressly **exempts 80% FPL and MAGI adults, and warns that the substantial home ownership valuation rules *do* apply to MAGI**. Va. Medicaid Manual §M 1480.010 B 6 states that "[f]or purposes of determining the combined and separate resources of the institutionalized and community spouses when determining the institutionalized spouse's eligibility, the couple's home, contiguous property, household goods, and one automobile are excluded."

[56] Va. Medicaid Manual § M 1460.530 (B)(3).

[57] Va. Medicaid Manual § M 1480.010 B (6); Va. Medicaid Manual § M 1480.210, .220 (B)(2).

when the applicant / recipient is in the 80% FPL category[58]) is exempt for six months after institutionalization, or longer when certain persons[59] reside there.

iv. ***Caveat:*** $713,000 Home Equity Limitation.[60]

1. Virginia's rule is that home property that exceeds the limit will make the homeowner ineligible for Medicaid payment of LTC services, unless the home is occupied by a spouse, dependent child under age 21, or a blind or disabled child of any age.[61]

2. During the life of the community spouse, the limitation can be avoided:

   A. While the community spouse resides in the home.

   B. If the institutionalized spouse transfers the home (or any portion of the same, sufficient to reduce the institutionalized spouse's share) to the community spouse.[62]

3. Thus the home and all real estate contiguous to it is excluded as long as the community spouse resides in the home.

b. Life estate in real property.

i. Life estates created before August 28, 2008, are exempt resources.

ii. Life estates created on and after August 28, 2008 but before February 23, 2009, are to be treated in the same manner as real property, including the application of real property exclusions, if any.

iii. Life estates created on or after February 24, 2009, are exempt resources.[63]

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[58] For the 80% FPL applicant or recipient, "[t]he home exclusion applies not only to the plot of land on which the home is located, but to any land that adjoins it." Medicaid Manual § S 1130.100. The Home and other exempt resources are collected in a table with references to specific policy provisions. Va. Medicaid Manual §M 1120.210. These are linked *supra*.

[59] Spouse, minor or disabled children, etc. See Medicaid Manual § M 1130.100.

[60] Va. Medicaid Manual § M 1460.150. ***The limit changes each year***.

[61] *Id.*

[62] Except in consideration of the community spouse's individual debts (especially those reduced to judgments, thus creating liens), it would be rare for a well advised institutionalized spouse not to transfer his entire interest in the home to the community spouse to avoid loss of benefits should the spouse precede him in death, and to avoid Medicaid estate recovery. Sometimes the community spouse is in poor health and the institutionalized spouse near death. In such a case, a transfer from the spouses to the institutionalized spouse may be considered. The institutionalized spouse might fund a testamentary trust for the community spouse, or bypass the community spouse altogether, as described below.

[63] Medicaid Manual § M 1110.515 B. Note: a life estate created by a "QDWI," a qualified disabled working individual, is counted regardless of the date of its creation. Va. Medicaid Manual §M 1140.110 A 6. d. 12 VAC 30-40-290 C provides that "[l]ife rights to real property are not counted as a resource. The purchase of a life right in another individual's home is

iv. *Caveat*. While a life estate purchased after February 23, 2009 will be exempt, the **funds "to purchase a life estate *in another individual's home*** [emphasis supplied by R. Shawn Majette] **on or after February 8, 2006" triggers an uncompensated asset transfer analysis**.[64] Failure to reside in the home of another in which a life estate is purchased for at least 12 consecutive months **after** the purchase[65] could therefore result in an uncompensated transfer of assets (equal to the purchase price for the life estate).

a. United States EE or I Savings Bonds.[66]

i. U.S. Savings Bonds are resources the first month following the mandatory retention periods listed:

1. 6 months for Series E, EE and I bonds issued prior to 2/1/03,

2. 12 months for Series EE and Series I bonds issued on or after 2/1/03, and

3. 6 months for Series H and HH bonds.[67]

ii. I-Bonds and EE Bonds issued on or after February 1, 2003, are subject to a twelve month mandatory holding period, during which they are 'not … resource[s] at all.'[68]

iii. Treasury dollar and timing limitations on the acquisition of the bonds.[69]

1. Purchases are limited to $10,000 per Social Security number in each series of EE and I bonds.[70]

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subject to transfer of asset rules. See 12VAC30-40-300."

[64] Va. Medicaid Manual § M 1450.545 B. "For Medicaid purposes, the purchase of a life estate is said to have occurred when an individual acquires or retains a life estate as a result of a single purchase transaction or a series of financial and real estate transactions." The language conflicts with federal law, which CMS has expressly interpreted to apply only to the purchase of a life estate in the residence of another, not to retaining the right to live in a house for the rest of the individual's life while selling the remainder in the individual's home to another party. See CMS State Medicaid Directors Letter, July 27, 2006 with CMS SMDL #06-018 Enclosure, § IV, discussed *infra*.

As to enforceability, see Loper Bright discussion *supra* and writer's case law update for 2024 published by the Virginia Law Foundation CLE program.

[65] 12 V.A.C. 30-40-300 (F) (1) *Definitions* [for purpose of uncompensated transfer of assets penalty determination]: "The term 'assets' includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least one year after the date of the purchase."

[66] Va. Medicaid Manual §§ M 1140.240 A; 1110.305 C 1 (example).

[67] H and HH bonds are no longer available.

[68] Va. Medicaid Manual § M 1110.305 C 1 (example), *supra*.

[69] See http://www.treasurydirect.gov/indiv/products/prod_eebonds_glance.htm. EE bonds yield is 2.70% until October 31, 2024.

[70] "Effective January 4, 2012, the annual (calendar year) purchase limit applying to electronic Series EE and Series I

2. Separate $5,000 limit applies to Series I savings bonds in paper, which may only be purchased with federal tax refund.[71]

3. Denominations.

A. Series I savings paper bonds (with tax refund only): $50, $100, $200, $500, $1,000. Series I electronic bonds via TreasuryDirect[72] purchased to the penny for $25 or more.[73]

B. EE[74] savings bonds via TreasuryDirect[75] purchased to the penny for $25 or more.[76]

iv. There is a penalty for redemption within five years of purchase. Redemption will generally be required as of the first date that the bond(s) can be counted as a resource.[77] The penalty is forfeiture of interest for 3 months immediately preceding redemption.

b. Motor vehicle of any value.[78]

c. Burial arrangements.

i. Burial space or agreements which represent the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value.[79] Cemetery plots are exempt regardless of number owned (except QDWI) and may not necessarily be limited to the use of the individual or other family members.[80]

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savings bonds is $10,000 for each series. The limit is applied per Social Security Number (SSN) or Taxpayer Identification Number (TIN). See Purchase Limits.

[71] Paper I bonds can only be purchased with federal tax refunds. See I Savings Bonds.

[72] See https://www.treasurydirect.gov/tdhome.htm.

[73] I Series generally, https://www.treasurydirect.gov/indiv/products/prod_ibonds_glance.htm.

[74] EE Series generally, https://www.treasurydirect.gov/indiv/products/prod_eebonds_glance.htm. Purchase link (opening a new account), https://www.treasurydirect.gov/RS/UN-AccountCreate.do.

[75] General Instructions, https://www.treasurydirect.gov/tdhome.htm.

[76] See https://www.treasurydirect.gov/indiv/products/prod_eebonds_glance.htm.

[77] "U.S. Savings Bonds are not resources during a mandatory retention period. They are resources (not income) as of the first day of the month following the mandatory retention period." Va. Medicaid Manual §M 1140.240 B 3.

[78] Generally, Medicaid Manual § M 1130.200. An automobile is excluded for the CS with an institutionalized spouse. Va. Medicaid Manual § M 1480.010 B (6); Va. Medicaid Manual § M 1480.210, -220 (B)(2).

[79] Va. Medicaid Manual § M 1130.400, See helpful Table, Va. Medicaid Manual § M 1110.210.

[80] "Cemetery plots are not *counted as resources, regardless of the number owned,* except when evaluating eligibility as QDWI. … *Accept declaration regarding ownership of cemetery plots. Verification is not required.*" Va. Medicaid Manual

1. The burial space exclusion is in addition to, and has no effect on, the burial funds exclusion below.[81]

ii. Burial funds set aside for expenses.

1. Single person or married couple when both spouses reside together: $3,500 burial account.[82]

2. Married persons under the spousal impoverishment policy at Va. Medicaid Manual § M 1480.000 *et seq*: $1,500 burial account each,[83] perhaps because two can die as cheaply as one?[84]

iii. Burial insurance policies,[85] unlimited in value.[86]

iv. Tangible personal property for the grave is considered a burial space, and is exempt regardless of value.[87]

d. Household goods and personal effects are excluded from countable resources.[88]

i. Household goods are items of personal property customarily found in the home and used in connection with the maintenance, use, and occupancy of the premises as a home.

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§ M 1130.400. *Cf*. TSD.

[81] Va. Medicaid Manual § M1130.400 A 2, *supra*.

[82] Va. Medicaid Manual § M 1130.410. "Up to $3,500 of burial funds may be excluded for each member of the ABD assistance unit (i.e., the individual and the individual's spouse, **if living together**)."

[83] Va. Medicaid Manual § M 1480.220 (B) (2). "For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined … using … policy in Chapter S11, regardless of the individual's covered group and regardless of community property laws or division of marital property laws, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share [**when one spouse is institutionalized and applying for long term care benefits and the other is not**]: … up to $1,500 of burial funds for each spouse (NOT $3,500*), if there are designated burial funds*." (Emphasis in original.)

[84] But hopefully not.

[85] "A burial insurance policy is a contract whose terms preclude the use of its proceeds for anything other than payment of the insured's burial expenses." Va. Medicaid Manual § M 1130.300 (A) 8.

[86] In determining the value of life insurance on the individual, burial funds and term policies do not count because "[a] life insurance policy owned by the individual is a resource if it generates a [cash surrender value] CSV." Va. Medicaid Manual § M 1130.300 (B) 1. However, burial insurance on the life of the individual reduces the burial set aside limit. Va. Medicaid Manual § M 1130.300 (B) 4.

[87] Va. Medicaid Manual § M 1130.400 (A).

[88] Medicaid Manual § M 1130.430. Household goods include but are not limited to flatware, place settings, statutes, and possibly ghosts.

ii. Personal effects are items of personal property that are worn or carried by an individual or that have an intimate relation to the individual.

a. Qualifying annuities.[89]

i. An annuity which is not purchased with the assets of a third party such as those received through a legal settlement is a countable resource unless it meets certain requirements.[90]

ii. An annuity purchased not purchased with third party settlement or similar funds is considered a countable resource unless it meets certain requirements.[91]

iii. A non-employment related annuity will be a countable resource unless the annuity:

1. is irrevocable;
2. is non-assignable;
3. is actuarially sound; and
4. provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.[92]

iv. *Caveat*: Based upon the foregoing policy, if the annuity is not actuarially sound, Virginia can deem an otherwise excluded annuity as a countable resource *and* imposes a period of ineligibility upon its acquisition.[93]

2. Personal resource allowance for countable resources of any aged, blind or disabled Medicaid recipient is limited to $2,000.

3. Lump sum for protection of the community spouse.

a. The Community Spouse Resource Allowance ("CSRA")[94] or the Community Spouse Protected Resource Amount ("CSPRA")[95] is the value of countable resources which can

[89] See discussion at III. B. 6., below.

[90] Va. Medicaid Manual §M 1140.260 B 2 exempts legal settlement and other third party purchased annuities.

[91] Va. Medicaid Manual §M 1140.260.

[92] *Id.* (B)(4).

[93] Va. Medicaid Manual §M 1450.520 (B) (2) provides that "[a]n annuity [*other than an employment related annuity*] purchased by the institutionalized individual on or after February 8, 2006, will be considered an uncompensated transfer unless … the annuity is: irrevocable and non-assignable; actuarially sound (see M1450.520 C. and reference to the Life Expectancy Table, Appendix 2; and provides for equal payments with no deferral and no balloon payments."

[94] Va. Medicaid Manual § M 1480.010 (B) (4).

[95] Va. Medicaid Manual § M 1480.010 (B) (25).

be excluded from the couple's countable resources, and thus protected for the community spouse ("CS") while the institutionalized spouse ("IS") receives Medicaid.

b. 50% of countable resources owned by spouses as of first day of month in which one spouse becomes institutionalized, subject to:

   i. Minimum (as of 1/1/**2024** until the first day of January following the date of this work): $30,822.[96]

   ii. Maximum[97] (as of 1/1/**2024** until the first day of January following the date of this work) $1545,140.[98]

c. Resource valuation and eligibility dates different for unmarried vs. married institutionalized person.

   i. For *unmarried* institutionalized applicant, valued at any time in the month (the "any day in month" rule).[99]

   ii. For *married* institutionalized spouse, resource eligibility exists when the total of all countable resources of *both* the IS and CS does not exceed the CSRA / CSPRA + $2,000 on the first day of the calendar month for which eligibility is being determined.[100]

d. For IS with CS.

   i. Assets (of both spouses) are initially valued on what is often referred to as the "snapshot date."

      1. Snapshot date is 1st day of the month in which the IS becomes "institutionalized."[101]

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[96] Va. Medicaid Manual M 1480.231.

[97] See III B below regarding limited revisions (institutionalization before DRA 2005).

[98] Va. Medicaid Manual §M 1480.231. See Exhibit A., *infra*. These limits are published annually by CMMS, generally at this link: https://www.medicaid.gov/medicaid/eligibility/spousal-impoverishment/index.html, accessible clicking on Exhibit A.

[99] Medicaid Manual § M 1110.600 (A) (1) states that "[w]e make all resource determinations per calendar month. Resource eligibility exists for the full month if countable resources were at or below the resource standard for any part of the month."

[100] Valuation ("**For resource assessment and eligibility determination, the resource value is its value**

as of the first moment of the first day of a calendar month." (Emphasis in original)), Va. Medicaid Manual § M 1480.000 A; eligibility as of such date, -230 (B).

[101]Va. Medicaid Manual § M 1480.010 (B) (12). Va. Medicaid Manual § M 1480.200 (A) provides that a "resource assessment is strictly a: compilation of a couple's reported resources that exist(ed) at the first moment of the first day of the month in which the first continuous period of institutionalization began on or after September 30, 1989."

2. A person is "institutionalized" on the first day of month of admission to nursing home when residence is expected for at least 30 consecutive days.[102]

3. Snapshot can be based on any institutionalization, in a nursing home or otherwise.[103]

e. A couple with "excess resources" cannot become resource eligible in the month of institutionalization.[104]

f. Post-eligibility increases in resources of CS immaterial to eligibility of IS.[105]

F. Transfer of Resources: 12 VAC 30-40-300; §M 1450 *et seq.*

1. Criminal liability.

a. So called "Granny I" and "Granny II" statutes enacted and amended in 1997 and 1998, respectively, created criminal exposure in relation to asset transfers.

i. Granny I initially targeted transferors – "Grannies" - who made transfers of assets to qualify for Medicaid benefits.

ii. Granny II amended the law to exempt seniors but substituted their paid advisors, under language in 42 U.S.C. 1320a-7b, which made it a crime to "knowingly and willfully counsel[] or assist[] an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under [Medicaid] if disposing of the assets results in the imposition of a period of ineligibility for such assistance." Such representation is punished as "a

[102] Medicaid Manual § M 1480.010 (B) (15) ("Institutionalized Spouse means an individual who: is in a medical institution, or who is receiving Medicaid waiver services, or who has elected hospice services; is likely to remain in the facility, or to receive waiver or hospice services for at least 30 consecutive days; and who is married to a spouse who is NOT in a medical institution or nursing facility."

[103] "Institutionalization means receipt of 30 consecutive days of care in a medical institution (such as a nursing facility), or waiver services (such as community-based care); or a combination of the two." Medicaid Manual § M 1410.010 (B) (2); § M 1480.010 (B) (15) (married persons).

[104] Medicaid Manual § M 1480.230 (B) states that when "determining eligibility of an institutionalized spouse with excess resources, an institutionalized spouse **cannot** establish resource eligibility by reducing resources within the month. The institutionalized spouse may become eligible for Medicaid payment of LTC services when the institutionalized spouse's resources are equal to or below the $2,000 resource limit as of the first moment of the first day of a calendar month."

[105] Va. Medicaid Manual § M 1480.232 (A) 2. Va. Medicaid Manual § M 1480.200 (B) 3 provides that "[o]nce an institutionalized spouse has established Medicaid eligibility as a Non-MAGI institutionalized spouse, count only the institutionalized spouse's resources when redetermining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse." This section includes a commendably helpful table explaining and directing the Medicaid worker's imputation (or exclusion) of resources held by the institutionalized spouse and community spouse.

misdemeanor and upon conviction thereof fined not more than $20,000 or imprisoned for not more than one year, or both.

b. The legislation was held unconstitutional in *New York State Bar Assoc. v. Reno*, 999 F. Supp. 710, 715 (E.D.N.Y. 1998).

c. In fact, as the United States has conceded the statute "plainly unconstitutional," cautious attorneys seeking additional relief from its reach have been denied on the basis of a lack of a justiciable controversy. See, *e.g.*, *Magee v. Reno*, 93 F. Supp, 2d 161, 162 (D.R.I. 2000).[106]

d. While criminal prosecution for uncompensated transfer of assets (or advice and assistance to effect such transfers) has been enjoined and does not appear to have resulted in any published case as of **2024**, criminal[107] and civil liability for the use of "willful false statement, (ii) willful misrepresentation or concealment of a material fact, or (iii) any other fraudulent scheme or device," does.[108]

2. Transfers by either spouse affects both spouses *when made before initial eligibility established* for the IS.

a. Transfers by a community spouse which cause ineligibility of the institutionalized spouse will be apportioned between the two spouses should the community spouse become institutionalized.[109]

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[106] "However, like self-censorship that is prompted by a fear of prosecution, self-censorship that stems from a desire to comply with the law must be subjectively felt and objectively reasonable. Here, there is no claim that the plaintiffs feel ethically constrained to obey Section 4734. On the contrary, they have made it clear that they believe Section 4734 to be unconstitutional. Moreover, the Attorney General, as the chief law enforcement officer responsible for upholding the laws, shares that belief and has disavowed any intention to prosecute alleged violations. Because a lawyer's obligation to uphold the Constitution takes precedence over the obligation to uphold a statute; and, because all concerned agree that Section 4734 is unconstitutional, the plaintiffs have failed to establish an objectively reasonable subjective belief that Section 4734 prevents them from properly counseling their clients."

See also Zahner v. MacKreth, Civil No. 11-306 Erie (W.D. Pa. Jan 16, 2014), in which the state of Pennsylvania sought to enforce the statute against attorneys counseling their clients in the acquisition of annuities, citing *Magee* to hold that the statute was not enforceable.

[107] Virginia Code § 32.1-321.4.

[108] "The Department of Medical Assistance Services (DMAS) investigates and accepts referrals regarding fraudulent and non-fraudulent payments made by the Medicaid Program. DMAS has the authority to recover any payment incorrectly made for services received by a Medicaid recipient or former Medicaid recipient. DMAS will attempt to recover these payments from the recipient or the recipient's income, assets, or estate, unless such property is otherwise exempt from collection efforts by State or Federal law or regulation." Va. Medicaid Manual §M 1700.100.

[109] "The couple may choose to either: • have the penalty period, or the remaining time in the penalty period,

divided between the spouses, or • assign the penalty period or remaining penalty period to one of the two spouses.

When one spouse is no longer subject to the penalty, such as one spouse is no longer institutionalized or one spouse dies, the remaining penalty period applicable to **both** spouses must be applied to the remaining spouse." Va. Medicaid Manual §

b. Transfers made by the community spouse *after eligibility has been established for the institutionalized spouse* have no effect upon eligibility of the institutionalized spouse, ***except*** as respects a non-conforming annuity purchased by the community spouse after eligibility. [110]

3. Exempt transfers.

a. Transfers exempt regardless of value or timing by reason of the character of the transferee, Va. Medicaid Manual § M 1450.400. [111]

i. Any property from spouse to spouse.

ii. Any property from spouse to Trustee of trust for sole benefit of spouse.

iii. Any property to applicant's child under age 21.

iv. Any property to applicant's blind or disabled child (of any age).

v. Any property to Trustee of a special needs trust per 42 USC 1396p(d)(4)(A) for disabled person under 65. [112]

vi. Any property to Trustee of "pooled" special needs trust for disabled persons under the age of 65 per 42 USC 1396p(d)(4)(C), with limitations.[113]

vii. An applicant's ***home*** may be transferred:

1. to a sibling or half sibling who has an equity interest in the home and who resided in the home for at least one year before the applicant / transferor became an institutionalized person.

M 1450.630 F.

[110] Va. Medicaid Manual § M 1450.400 (F) states that "[p]ost-eligibility transfers of resources owned by the community spouse (institutionalized spouse has no ownership interest) do not affect the institutionalized spouse's continued eligibility for Medicaid payment of LTC services. ***Exception*: The purchase of annuity by the community spouse on or after February 8, 2006 may be treated as an uncompensated transfer.**" (***Emphasis supplied*** by R. Shawn Majette.)

[111] Va. Medicaid Manual § M 1450.400.

[112] Va. Medicaid Manual §M 1450.400 D refers the reader to Va. Medicaid Manual § M 1120.202.

[113] "[P]lacement of an individual's funds into a pooled trust when the individual is age 65 years or older must be evaluated as an uncompensated transfer, if the trust is structured such that the individual irrevocably gives up ownership of funds placed in the trusts. A trust established for a disabled individual under age 65 years is exempt from the transfer of assets provisions. However, any funds placed in the trust after the individual turns 65 must be evaluated as an asset transfer." Va. Medicaid Manual §M 1450.550 (D).

As to enforceability, see Loper Bright discussion *supra* and writer's case law update for 2024 published by the Virginia Law Foundation CLE program.

2. to an adult child who resided in the home for at least two years immediately before the date the individual became institutionalized and provided care at home which would otherwise have been provided in a nursing home.[114]

b. Transfers in which the applicant's intention at the time of the transfer, or circumstances extant at the time of the application, cause the transfer to be disregarded.

i. Transfers in which the applicant intended to receive adequate compensation for the asset or that he/she actually received adequate compensation for the asset.[115]

ii. Transfers for reasons **exclusive** of becoming or remaining eligible for Medicaid long term care services' payment.[116]

iii. *De minimis* transfers after February 7, 2006.[117]

1. Transfers after February 7, 2006 with a total cumulative value not exceeding $1,000 per calendar year will not be considered a transfer for less than fair market value and no penalty period will be calculated.

2. Transfers after February 7, 2006, between $1,000 and $4,000 per calendar year will not be considered a transfer for less than fair market value if documentation is provided that such transfers follow a pattern that existed for at least three years prior to applying for Medicaid payment. Christmas gifts, birthday gifts, graduation gifts, wedding gifts, etc., meet the criteria for following a pattern that existed prior to applying for Medicaid payment of LTC services.

3. Although not factored into the examples provided by the Virginia Medicaid Manual, the exemptions effectively provide a reduction in penalties that can be

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[114] Va. Medicaid Manual § M 1450.400 (C) (3). SSI policy is more tolerant and realistic. POMS SI 01150.122 Exceptions—Transfer of a Home (C) provides simply that the "transfer of a home exception requires that the son or daughter (who received the transferred home) provided care that enabled the transferor to reside at home instead of in an institution or facility. Such care is substantial but not necessarily full-time care. A son or daughter is providing care for purposes of this exception if he/she does most of the following for the transferor on regular basis: prepares meals; shops for food and clothing; helps maintain the home; assists with financial affairs (banking, paying bills, taxes); runs errands; provides transportation; provides personal services; arranges for medical appointments; assists with medication."

The Virginia implementation of this exception to the transfer of assets penalty has been among the most egregiously at variance with federal statute, defying common sense. See Loper Bright discussion *supra*, the writer's case law update for 2024 published by the Virginia Law Foundation CLE program, and the reasoned opinion in Zehner, supra, in which the District Court could not see "counseling" as a distinct act from "transferring," implying that the courts will not participate in an absurd result.

[115] Va. Medicaid Manual § M 1450.400 B.

[116] *Id.*

[117] Va. Medicaid Manual § M 1450.400 H.

imposed by reason of a transfer for a minimum of 7 days and a maximum of 30 days per year in jurisdictions other than Northern Virginia.[118]

iv. Undue Hardship: Does Virginia Mean What Congress Said?[119]

1. 42 USC 1396p(c)(2)(C) provides that each State ***shall*** provide for a hardship waiver process in accordance with 42 U.S.C. 1396p(c)(2)(D))--

(1) under which an undue hardship ***exists*** when application of the transfer of assets provision would deprive the individual--
(A) of medical care such that the individual's health or life would be endangered; or
(B) of food, clothing, shelter, or other necessities of life; and

(2) which provides for--

(A) notice to recipients that an undue hardship exception exists;
(B) a timely process for determining whether an undue hardship waiver will be granted; and
(C) a process under which an adverse determination can be appealed.

2. The Centers for Medicare and Medicaid Services (CMS), previously HCFA, interpreted the statute and imposed specific requirements for state Medicaid programs in the CMS *State Medicaid Manual* (Transmittal 64) § 3258.10 (C) as follows:

> 4. Imposition of Penalty Would Work Undue Hardship.--When application of the transfer of assets provisions discussed in these sections would work an undue hardship, those provisions do not apply. Unlike the policies applying to transfers made on or before August 10, 1993, which only required that you acknowledge that the statute included an undue hardship provision, under OBRA 1993 you must implement an undue hardship procedure for transfers of assets. Further, that procedure must be described in your Medicaid State Plan. You have considerable flexibility in implementing an undue hardship provision. However, your undue hardship procedure must meet the requirements discussed in subsection 5.

[118] $1,000 / 207 [6,422/30] = 4 days; $4,000 / 207 = 19 days. Va. Medicaid Manual § M 1450.630 E (example).

[119] 12VAC 30-110-710, Undue Hardship; Transfer of Resources. Va. Medicaid Manual § M 1450.700.

5. Undue Hardship Defined.--Undue hardship exists when application of the transfer of assets provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life.

Undue hardship does not exist when application of the transfer of assets provisions merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him/her at risk of serious deprivation. You have considerable flexibility in deciding the circumstances under which you will not impose penalties under the transfer of assets provisions because of undue hardship.

For example, you can specify the criteria to be used in determining whether the individual's life or health would be endangered and whether application of a penalty would deprive the individual of food, clothing, or shelter.[120] You can also specify the extent to which an individual must make an effort to recover assets transferred for less than fair market value. As a general rule, you have the flexibility to establish whatever criteria you believe are appropriate, as long as you adhere to the basic definition of undue hardship described above.

3. The exclusive focus of the federal statute is upon the impact of the denial upon the Medicaid applicant / recipient.[121]

4. The penalty only applies to persons certified (by the prescreening process) to be in need of long term nursing care in a facility or in the community.[122] Every

[120] **As noted below, footnote 121 *et seq.*, every Medicaid recipient or applicant for LTSS care has ALREADY been screened to certify the need for Medicaid funded medical services that cannot be met *except* by the provision of long term care services (LTSS)**.

[121] See Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations July 27, 2006, Letter to State Medicaid Directors Number SMDL #06-018 Enclosure captioned, "Sections 6011 and 6016 New Medicaid Transfer of Asset Rules Under the Deficit Reduction Act of 2005." The letter and the enclosures address the transfer of asset penalties and policy for transactions allegedly being for less than fair market value, including purchase of promissory notes, loans, or mortgages, purchase of life estates, and undue hardship.

[122] Eligibility determinations follow a mandatory sequence. Va. Medicaid Manual § M 0130.300 (A). Before resource or transfer of assets policy is applied, Medicaid requires the applicant to be screened. *Id.* Screening for LTC / LTSS is a

such person must have that level of care to have their minimal activities of daily living met. ***Thus, every denial of Medicaid funding for long term care services that results in denial of admission or expulsion from a nursing home will meet the standard for endangerment and privation.***

5. The present policy provides that undue hardship "***may*** exist when the imposition of a transfer of assets penalty period would deprive the individual of medical care such that the individual's health or life would be endangered or he would be deprived of food, clothing, shelter, or other necessities of life."[123]

6. Further limitations – arguably in violation of federal law - are cobbled onto the exception in Virginia, by virtue of the policy that "[a]n undue hardship may be granted when documentation is provided that shows:

   A. that the assets transferred cannot be recovered, and

   B. that the immediate adverse impact of the denial of Medicaid coverage for payment of LTC services due to the uncompensated transfer would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life."

   C. Virginia requires a specific form[124] to be completed, and provides a minimum of 10 days in which to return the completed form claiming undue hardship, and if the individual requests additional time to provide the form and documentation, the worker must allow up to 30 calendar days from the date the checklist requesting information was sent. If the form and

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nonfinancial requirement for all persons seeking Medicaid coverage for such care. Va. Medicaid Manual § M 1420.100 (B) (2). "*In order to qualify for nursing facility care, an individual must be* ***determined to meet functional criteria, have a medical or nursing need and be at risk of nursing facility or hospital placement within 30 days without services****."* Va. Medicaid Manual § M1420.200 B (Italics in original, underlined highlighting by writer.)

Only after a person is screened as requiring LTC supports does Medicaid determine financial requirements, Va. Medicaid Manual § M 0130.300 (A), including analysis of the person's transfer of assets. "Individuals who are eligible for Medicaid may NOT be eligible for Medicaid payment of long-term care (LTC) services, *also referred to as long-term services and supports (LTSS),* for a specific period of time (penalty period) if they or their spouses have transferred assets for less than fair market value without receiving adequate compensation. The asset transfer policy applies to all individuals in all types of *LTSS: facility based and community based care (CBC), also referred to as home and community based services (HCBS)."*(Emphasis in original). Va. Medicaid Manual § M 1450.001.

[123] Va. Medicaid Manual § M1450.004 P; Va. Medicaid Manual § M 1450.700 B 1 a.

[124] Form.

documentation are not returned within *30* calendar days, the penalty period must be imposed.[125]

7. In stark contrast, Virginia requires specific documentation that is entirely without justification in the federal statute's intentionally limited scope. The scope is limited because the Commonwealth, in imposing the penalty, will be denying essential medical care necessary to maintain life. Federal limitations on the Commonwealth's power to deprive the otherwise eligible Medicaid recipient of care are exceeded in the Commonwealth's requirements, especially when considered in practice. They always apply to only persons screened as needing the care.[126]

   The requirements *always* apply to a resident who cannot possibly pay for them. To take a single example, they *always* require copies of documents and reports from third parties. In *virtually every case* legal and accounting skills are required to search titles, interact with physicians, and then identify and obtain documents which an impoverished nursing home resident – already determined to be "otherwise eligible" and therefore impoverished - cannot hope to pay.

   Bad as they are as written, they are worse in actual practice.

   The requirements will *likely* apply to a cognitively impaired resident[127] confined to a nursing home.

   Finally, they require the same proof of facts which the exhaustively intrusive pre-screening and Medicaid application process have already verified.

   The demanded documents:[128]

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[125] Medicaid Manual § M 1450.700 B. 1. b.

[126] See *Prescreening: Activities of Daily Living / U.A.I., §M1420.100*, *supra*.

[127] The United States Centers for Disease Control and Prevention reported in February 2019, that the percentage of persons residing in nursing homes for 100 days or more diagnosed with Alzheimer's disease and other dementias was 58.9%. *Table IX. Nursing home residents, by selected characteristics and length of stay: United States, 2016*," Long-term Care Providers and Services Users in the United States, 2015–2016, Vital and Health Statistics, Series 3, Number 43, p. 78.

"More than 50 percent of residents in assisted living and nursing homes have some form of dementia or cognitive impairment, and that number is increasing every day," according to the Alzheimer's Association, which determined that "that about 67 percent of dementia-related deaths occur in nursing homes." Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes, accessed 8/21/2024 3:26:41 PM.

[128] Va. Medicaid Manual §M 1450.700 B (1) (a).

A. the reason(s) for the transfer;

B. attempts made to recover the asset, including legal actions and the results of the attempts;[129]

C. notice of pending discharge from the facility, or discharge from PACE, hospice, or CBC services due to denial or cancellation of Medicaid payment for these services and include the actual date discharge will take place;[130]

D. physician's statement stating the inability to receive nursing facility or CBC services would result in the applicant/recipient's inability to obtain life-sustaining medical care;

E. documentation that individual would not be able to obtain food, clothing, §§§shelter, or other necessities of life;[131]

F. list of all assets owned and verification of their value at the time of the transfer if the individual claims he did not transfer resources to become Medicaid eligible;[132] and

G. documents such as deeds or wills if ownership of real property is an issue.

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[129] There is no basis in federal law nor in the Virginia Administrative Code for any attempt to recover property through a court proceeding. In policy captioned "No Access Without Litigation," Virginia Medicaid policy expressly declares that Virginia does ***not*** require litigation to obtain access to a resource not in the possession of the individual. Va. Medicaid Manual § S 1120.010 (C)(2), (D)(6).

[130] **This provision results in a legal impossibility in nursing facility cases**. A facility may not discharge a resident for non-payment while a Medicaid application is pending or when an appeal is filed. Once a resident is admitted, the facility has a duty to provide for a safe and orderly discharge. When the resident requires further care but has insufficient income and resources to do so – by definition the case of a Medicaid resident - the host facility cannot discharge without finding another facility willing to provide the same level of care for the same non-existent returns.

"Discharge planning [by the host facility attempting to discharge for non-payment] must identify the discharge destination, and ensure it meets the resident's health and safety needs, as well as preferences." CMS *State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities* (Rev. 225; Issued: *08-08-24*). The discharge process requirement is described at § 483.21(c)(1). Prohibitions on discharge upon Medicaid application or, with denial, appeal, see p. 179 483.15(c)(1)(ii).

Thus speaks the Virginia Department of Health Office of Licensure and Certification, Resident Transfer and Discharge Guideline (accessed 8-22-2024 at 11:18).

As to enforceability, see Loper Bright discussion *supra* and writer's case law update for 2024 published by the Virginia Law Foundation CLE program.

[131] Since the Medicaid agency will already have required proof that the sick resident is medically needy (or medically indigent), of what does this documentation consist?

[132] There is no basis in federal law nor in the Virginia Administrative Code for the assertion that the resident or applicant make any such declaration.

8. All requests for waivers under the undue hardship standard must be considered by the central DMAS office.[133]

9. Denial of an unclaimed hardship exception may be appealed[134] pursuant to Virginia Administrative Code provisions.[135]

c. Transfers exempt by reason of the character or value of the transferred asset.[136]

i. Personal Effects and Household Items.

ii. Automobiles.

1. If used for employment or treatment transportation, or which are specifically equipped for disabled persons, no limitation on value.

2. Otherwise, automobile of up to $4,500 in trade-in value is excluded.

iii. Life insurance.

1. Term life policies, no limitation on transfer amount.

2. Other policies, up to $1,500 in face value.

iv. Property essential to self-support (business use property).

4. Disqualifying Transfers: The look-back and the penalty.

a. Ineligibility is imposed, if at all, only for long term care services, including nursing facility services and home or community based care services under the Virginia waiver.[137]

b. The look-back, 42 USC 1396p.

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[133] Va. Medicaid Manual §M 1450.700.

[134] "The individual must be informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110." Va. Medicaid Manual §M 1450.700 (B) 1 e.

[135] 12 VAC 30-110-90. In practice there is little possibility that an eligible recipient, all of whose income other than a pittance (less than $1.33 per day) will retain (a) sufficient mental capacity and (b) financial resources to engage professionals needed for the purpose.

[136] Va. Medicaid Manual § M 1450.300.

[137] "As long as an individual in a penalty period meets a full or limited-benefit Medicaid covered group and all nonfinancial and financial requirements for that covered group, he is eligible for all services covered under that group EXCEPT the Medicaid payment of *LTSS."* Va. Medicaid Manual § M 1450.630 (A); Va. Medicaid Manual § M 1450.004 (excellent flow chart).

i. The look-back is the period of time in which Medicaid may consider gifts and under-valued sales ("uncompensated transfers") to disqualify an applicant / spouse from certain Medicaid services.

ii. The look-back for uncompensated transfers made after February 7, 2006, is sixty months.[138]

c. Penalty calculation for long term care services by reason of uncompensated transfers effected within the look-back.

i. Uncompensated transfers made within the look-back.

1. Calculate period of ineligibility for uncompensated transfers in the 60 month period preceding application date.[139]

A. Single gift within look-back.[140]

a. Divide value of gift by average monthly cost of private nursing home payment $6,422 ($9,032 in Northern Virginia).[141]

b. Quotient is the ineligibility period, which is the number of months and partial months (days) of ineligibility for long term care services.[142]

i. Example: Applicant's $10,000 gift on October 9.

ii. $10,000 / $6,422 = 1.557

iii. 10,000 – 6,422 = $3,578 [partial month]

iv. Daily rate is 6,422 / 31 = $207.16

v. 3,578 / $207.16 = 17.271 days.

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[138] "When a Medicaid applicant reports an asset transfer, or the worker discovers a transfer, determine if the transfer occurred within 60 months prior to the month in which the individual is both institutionalized and a Medicaid applicant/enrollee." Va. Medicaid Manual § M 1450.200 (B).

[139] 42 U.S.C. 1396p (c) (1) (E) (i) (I) [requiring consideration of "the total, cumulative uncompensated value of all assets … on or after the look-back date", for institutionalized persons], and 42 U.S.C. 1396p (c) (1) (E) (ii) (I) [same, for non-institutionalized persons].

[140] Medicaid Manual § M 1450.400 (H), discussed above, provides a de minimis exemption between $1,000 and $4,000, from the transfers of assets penalty. The exemption has not been factored into this equation. The exemption is discussed above.

[141] **CAVEAT AND NOTICE: the example is using old (pre-2024) penalty divisor**. The present divisors are *$9,268 / $7,023* Va. Medicaid Manual § M 1450.630 D.

[142] Va. Medicaid Manual § M 1450.630 E provides details on the calculation of partial months of ineligibility for transfers.

vi. Ineligibility period = 1 month, 17 days. [143]

B. Multiple gifts in look-back. [144]

a. Add the total, cumulative value of all assets transferred.

b. Divide total by average monthly cost of private nursing home payment $6,422 ($9,032 in Northern Virginia).[145]

c. Quotient is the ineligibility period, which is the number of months (& partial months) of ineligibility for long term care services.

d. Example: Richmond applicant's $10,000 gift on October 9, and of $10,000 on November 5.

i. $20,000 / $6,422 = 3.11.

ii. Ineligibility period = 3 months 13 days.[146]

2. Commence calculated ineligibility period from the later of:

A. First day of month during or after which assets have been transferred for less than fair market value, or

B. the date on which the individual is eligible for Medicaid and would otherwise be receiving institutional level care but for the application of the penalty period, and which does not occur in any other period ineligibility imposed for any other reason.[147]

C. Example:

a. Grandmother pays $5,000 tuition for her 19 year old grandchild on May 6. In January in the following year, she pays $14,266 for medical bills of her adult (non-disabled) daughter.

b. Grandmother (or Grandfather) slips, breaks her hip, and cannot return home. She enters a nursing home in April.

c. She exhausts her income and remaining assets as of September.

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[143] The penalty period includes the fractional portion of the month, rounded down to a day. Medicaid Manual § M 1450.630 A.

[144] Caveat: Va. Medicaid Manual § M 1450.400 H, discussed above, provides a *de minimis* exemption between $1,000 and $4,000, from the transfers of assets penalty. The exemption has not been factored into this equation.

[145] Va. Medicaid Manual M 1450.630 (D).

[146] Medicaid Manual § M 1450.630, *op. cit.*

[147] Va. Medicaid Manual § M 1450.630 B.

d. Her application for benefits is otherwise granted, in Richmond, Virginia, in the same month. She receives Medicaid except for her nursing home expense.

e. With these transfers (totaling $19,266), Grandmother is ineligible for Medicaid for 3 months, 0 days,[148] commencing September 1, and concluding on December 2.[149]

II. Planning Considerations: Initial Eligibility For Institutionalized Spouse.[150]

Example:

- H and W own a home and have non-working farmland which is contiguous to the home.
- They own real estate valued at $200,000 with no mortgage.
- They have $200,000 in cash or stocks.
- She has Social Security Administration benefits of $500 per month.
- He has Social Security Administration benefits of $1,100 and a private pension of $350.
- He goes into the nursing home on August 3.
- No gifts of any kind (including Christmas, birthdays, etc.) made in preceding five years, or gifts having no greater value than $1,000 made in any calendar year.[151]
- Powers of attorney with gifting authority in place.[152]

A. Initial eligibility.

[148] $19,266/ 6,422 = 3.00. **CAVEAT AND NOTICE: the example is using old (pre-2024) penalty divisor.**

[149] Va. Medicaid Manual § M 1450.630 B. The penalty does not commence until September because that is the first day of the month in which the applicant is institutionalized and otherwise eligible for nursing home care based upon an approved application, *viz*, "the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTSS, except for the imposition of a penalty period. This includes the application retroactive period for nursing facility patients who have been in the facility during the retroactive period."

[150] **CAVEAT AND NOTICE: the example may employ prior year allowances for community spouse protected resource amount (Va. Medicaid Manual § M 1480.231, in 2024) and community spouse minimum maintenance needs (Va. Medicaid Manual § M 1480.410, in 2024). See discussion supra. Reader, please confirm present limit amounts at the CMS site (https://www.medicaid.gov/medicaid/eligibility/spousal-impoverishment/index.html).**

[151] Va. Medicaid Manual §M 1450.400 H provides a $1,000 per year exclusion which may be increased to $4,000 per year for traditional "pattern" gifts: "Assets transferred on or after February 8, 2006, that have a total cumulative value of more than $1,000 but less than or equal to $4,000 per calendar year may not be considered a transfer for less than fair market value if documentation is provided that such transfers follow a pattern that existed for at least three years prior to applying for Medicaid payment of LTSS services. Christmas gifts, birthday gifts, graduation gifts, wedding gifts, etc. meet the criteria for following a pattern that existed prior to applying for Medicaid payment of LTSS services.

[152] The Virginia Uniform Power of Attorney Act , § 64.2-1622 (A) (2), prohibits gifts on behalf of an agent in the absence of express, specific authorization in the power of attorney.

a. Home is exempt as well as all contiguous real estate.[153]
b. CSPRA for W: $100,000 (1/2 of $200,000, not exceeding $154,140).[154]
c. MMNA for W: $2,555[155] - $500 (Soc. Sec. For Wife) = $2,055.
d. Excess resources, $98,000 ($200,000 – [$100,000+ $2,000]).
e. First possible eligibility date is September.

B. More Than A Baker's Dozen Excess Resource Dispositions – ***if they are needed***.[156]

1. Payment for long term care of IS and living expenses of CS.
2. Enhanced home, car, contiguous property to home.
3. Purchase of home for CS[157] and creation of HECM reverse mortgage for CS.
   a. Purchase of home is exempt.
   b. Loan proceeds are excluded from income calculations.[158]

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[153] Only $5,000 in surrounding property would be exempt were H single unless the single H qualified under the 80% FPL category.

[154] Caveat: Current year values in equation unless otherwise marked. Va. Medicaid Manual § M 1480.231

[155] Va. Medicaid Manual M 1480.410.

[156] Resources of a MAGI eligible institutionalized person are immaterial in Long Term Support and Services (LTSS).

About 39% of persons requiring Long Term Support and Services were under 65 in 2015. "In the United States approximately 6.1 million adults with disabilities younger than age sixty-five were estimated to require long-term services and supports (LTSS) as of 2018.[1] Most receive support from family or paid caregivers or both. Others receive services within supportive housing, group homes, shared living, institutions, and other residential service arrangements, including nursing homes.[2] As of fiscal year 2013, the most recent year of published data, approximately 17 percent of those who used Medicaid LTSS who were ages 21–64 and 1 percent of those younger than age 21 resided in a nursing home." *Nursing Home Residents Younger Than Age Sixty-Five Are Unique And Would Benefit From Targeted Policy Making*. Ari Ne'eman, Michael Stein, and David C. Grabowski, 2022.

For those without Medicare, "no resource test is applicable for MAGI Adults coverage." However, "certain resources for any individuals seeking Medicaid payment for LTSS [are considered,] includ[ing] asset transfers, trusts, annuities, and the home equity limit." Va. Medicaid Manual §M 1460.207. "Resource Assessment policy [for an IS] does not apply to individuals eligible in the MAGI Adult covered group. However, a resource assessment may be needed when a married individual FORMERLY received LTSS as a MAGI Adult, and needs to be re-evaluated for LTSS in a non-MAGI group." Va. Medicaid Manual §M 1480.200 B 1.

[157] Note the home equity limitation does not apply since the community spouse will own (and live) in the home.

[158] Va. Medicaid Manual § M 1120.225 B. See HUD Handbook 4000.1, published 10-31-2023, specifically providing that "[t]his update to the FHA Single Family Housing Policy Handbook, or Handbook 4000.1, is to incorporate guidance for FHA's Title II Insured HECM program." See Part B, Title II Insured Housing Programs Reverse Mortgages; the writer's 2014 entitlements oriented outline; and HECM Financial Assessment And Property Charge Guide Revised July 13, 2016

4. Long term care insurance for CS.

5. Enhanced (increased) CSRA when sum of CS and IS income less than MMNA via fair hearing for institutionalizations occurring after February 7, 2006,[159] limited court order.[160]

6. Conversions of CS resources to income.

   a. Loan to child for non-negotiable, actuarially sound promissory note payable to CS.

      i. Transfer of assets analysis.[161]

         1. The note will not be considered an uncompensated transfer of assets if it:

            A. has a repayment term that is actuarially sound (see M1450.400),

            B. provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments, and

            C. prohibits the cancellation of the balance upon the death of the lender.

         2. If the promissory note, loan, or mortgage does not meet the above criteria, the uncompensated amount is the outstanding balance as of the date of the individual's application for Medicaid.

         3. The countable value as a resource is the outstanding principal balance for the month in which a determination is being made.

      ii. Resource analysis.[162]

         1. Presumption is that a promissory note is a countable resource.

(see esp. §§ 2.01, 2.12).

[159] 12VAC 30-110-856; §M 1480.232 F (1,3). See also Wis. Dep't of Health and Family Servs. v. Blumer, 543 U.S. 473 (2002).

[160] Va. Code § 20-88.02:1. See CMS SMDL #06-018 Enclosure, §6013 (income first), § 6011 (V) (undue hardship).

[161] Va. Medicaid Manual § M 1450.540. See also 42 USC 1396p (c) (1) (I) (providing that "with respect to a transfer of assets, the term "assets" includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage— (i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); (ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and (iii) prohibits the cancellation of the balance upon the death of the lender;' and 12VAC30-40-300 (F) (1), which provides "the term 'assets' [for which any penalty may be imposed] also includes funds used to purchase a promissory note, loan, or mortgage ***unless*** such note, loan, or mortgage: a. Has a repayment term that is actuarially sound (determined in accordance with actuarial publications of the Social Security Administration); b. Provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments made; and c. Prohibits the cancellation of the balance upon the death of the lender." *Emphasis* supplied by the writer.

[162] Va. Medicaid Manual § S 1140.300.

A. "A promissory note is a written, unconditional agreement whereby one party promises to pay a specified sum of money at a specified time (or on demand) to another party. It may be given in return for goods, *money loaned*, or services rendered."

B. The Medicaid worker is instructed to "[a]ssume that the value of a promissory note, loan, or property agreement as a resource is its outstanding principal balance unless the individual furnishes reliable evidence that it has a CMV of less than *the outstanding principal balance* (or no CMV at all)."

C. The Medicaid worker is further instructed that "[i]f including the outstanding principal balance in countable resources causes ineligibility, **inform the individual** that we will use the outstanding principal balance in determining resources unless he or she submits: • evidence of a legal bar to the sale of the agreement ; or • an estimate from a knowledgeable source, showing that the CMV of the agreement is less than its outstanding principal balance."

D. "Knowledgeable sources include anyone regularly engaged in the business of making such evaluations: e.g., banks or other financial institutions, private investors or real estate brokers. The estimate must show the name, title, and address of the source."

2. However, while a *non-negotiable, non-assignable* promissory note is an asset, under long established policy, it can never be a resource.

A. "Not everything a person owns (i.e., not every asset) is a resource and not all resources count against the resource limit."[163]

B. "Resources are cash and any other personal or real property that an individual (or spouse, if any):
• owns;
• ***has the right, authority, or power to convert to cash*** (if not already cash); and
• is not legally restricted from using for his/her support and maintenance."[164]

C. "Any property (an asset) that does not meet the criteria in 1. above is not a resource even though it may be an asset (e.g., an individual who has an ownership interest in property but is not legally able to transfer that interest to anyone else does not have a resource)."[165]

[163] Va. Medicaid Manual §M 1110.001 (B) (2); S 1110.100 A.

[164] Va. Medicaid Manual §S 1110.100 (B) (2).

[165] Va. Medicaid Manual §S 1110.100 B 3.

3. A community spouse's loan of funds to a child, in exchange for a non-negotiable, non-assignable, and non-transferable promissory note which meets the foregoing transfer of assets criteria will result in a resource which has a zero CMV for liquidation (as the note will require that payments be made only to the community spouse or to her estate regardless of any attempted sale or negotiation). The payments which the community spouse receives on a monthly basis will be attributable to her only as income.

b. Annuity for CS or single person (purchased after February 7, 2006).

i. Transfer of assets analysis.[166]

1. Virginia remainder-person.

A. To meet the remainder person test, the annuity must name the Commonwealth as a remainder beneficiary for at least the total amount of medical assistance paid on behalf of the "*institutionalized individual,"* the institutionalized spouse or the institutionalized person other than a spouse.

B. However, when there is a community spouse or minor or disabled child, the Commonwealth is a secondary remainder beneficiary.[167]

2. Irrevocability, actuarial soundness, and regularity; exception for tax annuities.[168]

Unless the annuity is described in IRC 408,[169] the purchase money paid for the annuity will be considered an uncompensated transfer of assets unless the annuity

A. is irrevocable and non-assignable; and

B. is actuarially sound;[170] and

C. provides for equal payments[171] with no deferral and no balloon payments.

ii. Resource analysis.[172]

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[166] Va. Medicaid Manual § M 1450.520. See also 42 USC 1396p (c) (1) (F).

[167] The policy states the state must be the remainder beneficiary "in the first position."

[168] Va. Medicaid Manual § M 1450.520 (B) (2) (a).

[169] IRC 408 includes IRA, simplified retirement accounts, simplified employee pension; Roth IRA, or certain other accounts established by employers and associations.

[170] Va. Medicaid Manual § M 1450.520 C, relevant to purchases of all annuities except those specifically excluded, including "the assets of a third party such as those received through a legal settlement are not considered to be countable resources." Va. Medicaid Manual § M 1140.260 B 2. See below.

[171] Not necessarily monthly payments.

[172] Va. Medicaid Manual § M 1140.260.

1. The annuity must be issued by an entity licensed to do business in the state in which the annuity is established.[173]
2. "Annuities purchased with the assets of a third party such as those *received* through a legal settlement are not considered to be countable resources."[174]
3. The annuity:[175]
   A. Must be irrevocable.
   B. Must be non-assignable.
   C. Must be actuarially sound.[176]
      a. Use the tables at Va. Medicaid Manual § M 1450, Appendix 2.[177]
      b. The annuity should be for no more than the life of the annuitant, and as long as the same does not exceed the life expectancy, will not be considered actuarially unsound so as to cause inclusion as a resource.[178]
      c. A state's attempt to characterize an otherwise compliant annuity as a "sham" because of its short term nature was held to violate federal law.[179]
   D. Must provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.
4. According to Va. Medicaid Manual § M 1140.260 (B)(5), "[p]rior to receiving long-term care services paid by Medicaid, all annuities purchased by the institutionalized individual *or the community spouse* on or after February 8,

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[173] Id. A.

[174] Id. (B) (2). This has been interpreted to include structured settlements in which the defendant's insurer buys the annuity in at least one case in Virginia. Would traceable third-party funds from inheritances, etc., also permit exclusion?

[175] Id. B 4.

[176] It is unclear whether an annuity for a community spouse must be actuarially sound.

[177] Direction to use, Va. Medicaid Manual § M 1450.520 C; Life Expectancy Table.

[178] "When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) is less than the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value." Va. Medicaid Manual § M 1450.610 D.

[179] "Congress created a 'safe harbor' pursuant to which [ ] certain annuities are not considered resources for purposes of Medicaid eligibility. Therefore, the value of such annuities does not disqualify those otherwise eligible for Medicaid assistance from Medicaid eligibility. See 42 U.S.C.S. § 1396p(c)(1)(G)(ii) …. as there was no requirement of a minimum term for an annuity to qualify under the safe harbor, and the annuities were actuarially sound because they did not exceed the annuitant's life expectancy." *Zahner v. Sec'y Pa. Dep't of Human Servs., 802 F.3d 497* (3rd Cir. 2015)(specifically rejecting that the annuities in issue were "trust-like").

2006, must name the Commonwealth of Virginia as the primary [remainder?] beneficiary for at least the total amount of medical assistance *paid on behalf of the institutionalized individual*. If there is a community spouse or minor or disabled child, the Commonwealth must be named as the remainder beneficiary behind the spouse or minor or disabled child."[180]

5. Reducing the payback period in the community spouse's annuity is permissible and perhaps advisable.

7. Burial Planning for H & W?[181]

8. Trust for disabled child of any age, or disabled person under age 65?[182]

9. "Pooled" Disability Trust for disabled person under 65 years of age?

   a. Trust is recognized as an exempt trust in Virginia Medicaid policy.[183]

   b. Transfers exempt as long as made to the trustee before age 65.[184]

10. Triple Scoop Self Settled Spendthrift Trust for MAGI eligible applicants?[185]

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[180] Does this provision conflict with Va. Medicaid Manual § M 1450.520 (B)(1)?

[181] Va. Medicaid Manual § M 1130.300, - 410 et seq.; §M 1450.510 B.1. (Burial insurance).

[182] Va. Medicaid Manual Va. Medicaid Manual § M 1120.202 (B) (resources); Va. Medicaid Manual § M 1450.400 (D) (uncompensated transfer of assets exemption).

[183] Va. Medicaid Manual § M 1120.202 (B) (2).

[184] See discussion above.

[185] A MAGI eligible settlor will have no excess resource disposition, because there is no resource test. Therefore an irrevocable trust funded by the MAGI settlor with settlor and at least one other discretionary beneficiary who *can* receive distributions of principal and income will insulate the settlor's interest in the trust corpus as a "qualified interest" under the Virginia self-settled trust statutes from most third party creditors without violating the Medicaid transfer of asset rule because under 42 USC 1396p and Virginia Medicaid policy, *all* of the trust corpus is counted as available to the settlor pursuant to Va. Medicaid Manual §M 1120.201 C 2 b, "[i]n the case of an irrevocable trust if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered • resources available to the individual, and • payments from that portion of the corpus or income to or for the benefit of the individual, shall be considered income of the individual, and • payments from that portion of the corpus or income for any other purpose, shall be considered a transfer of assets by" the Settlor. While distributions are considered income for purposes of ABD Medicaid eligibility, only *taxable* income is counted for MAGI eligibility. If distributions are made a non-settlor beneficiary, they are only considered as having been made by the Settlor, and will not trigger a penalty when to Settlor's disabled or minor child, or, ideally, a trustee of a payback (42 USC 1396p(d)(4)(A) or pooled (42 USC 1396p(d)(4)(C)) trust. Va. Code § 64.2-745.1, Va. Code § 64.2-745.2.

The instrument creating a triple dip trust will have powers of appointment or directions to fund any of the three trusts:

- the vanilla scoop (whether a spendthrift or not, but which is for the benefit of Settlor), be considered a countable resource to the settlor;
- the chocolate scoop, being a d4A trust for settlor when he is disabled and under 65, or become entitled by reason

11. Split interest (life/remainder estate planning)?

    a. Life estates are not countable resources.[186]

    b. No limitations in acquisition of life estate through February 7, 2006.

    c. Limitations after February 7, 2006.

        i. Acquisition life estate in another individual's home will be treated as uncompensated transfer of assets unless the purchaser resides in the home for at least twelve consecutive months after the acquisition.

        ii. According to CMS[187] and the Virginia Medicaid policy, the limitation applies only to acquisition of a life estate in the residence of another individual; thus it has no impact on life estates in commercial property or other non-residential home.

        iii. While CMS has interpreted federal law to state that the 12 month residence rule in inapplicable when the individual purchases a home and then conveys a remainder interest (for value) to a third party (because the individual owned a fee simple interest in a home and then conveyed a remainder interest to the third party), Virginia policy imposes a transfer of assets penalty.[188]

12. Contract for services rendered by family member ?[189]

    a. Services provided by the child to the Medicaid applicant, or the IS or CS, may be compensated.

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of Social Security Disability Income status for Medicare; and

- the strawberry scoop, to satisfy Medicare set aside rules and sheltered within the chocolate scoop, see M1140.500.

[186] Va. Medicaid Manual § M 1140.110 (A) (6) and § S 1140.110. See discussion above for life estates acquired between August 28, 2008, and February 23, 2009. A countable life estate could be sold to the remainder tenant for value, who could then simply sell it again to the applicant / recipient (albeit for a reduced value).

[187] State Medicaid Director Letter SMDL #06-018, July 27, 2006 and Enclosure: Sections 6011 and 6016 New Medicaid Transfer of Asset Rules Under the Deficit Reduction Act of 2005, accessed July 5, 2020.

[188] "The DRA provision pertaining to life estates does not apply to the retention or reservation of life estates by individuals transferring real property. In such cases, the value of the remainder interest, not the life estate, would be used in determining whether a transfer of assets has occurred and in calculating the period of ineligibility." CMS SMDL #06-018. Enclosure, § IV. However, as stated above, Virginia purports to apply the rule to a retained life estate in real estate in violation of the CMS position, applying the same to "funds" used to acquire the interest, stating that "for Medicaid purposes, the purchase of a life estate is said to have occurred when an individual acquires or retains a life estate as a result of a single purchase transaction or a series of financial and real estate transactions." Va. Medicaid Manual § M 1450.545 (B) (italics in original).

As to enforceability, see Loper Bright discussion *supra* and writer's case law update for 2024 published by the Virginia Law Foundation CLE program.

[189] Va. Medicaid Manual § M 1450.003 E, H, as modified by Va. Medicaid Manual § M 1450.570, Services Contracts.

b. ***Caveat*** income tax consequences.[190]

c. Limitations.

i. Physician statement stating types of services that were to be provided under the contract, and that these services were necessary to prevent the individual's entrance into LTC.[191]

ii. Advance lump sum payment for services that have not been performed is considered an uncompensated transfer of assets because the Medicaid applicant/recipient has not received valuable consideration.

iii. Payments to other individuals for services received after the individual enters LTC are considered an uncompensated transfer for Medicaid purposes, because "[o]nce an individual begins receipt of Medicaid LTC services, the individual's personal and medical needs are considered to be met by the LTC provider. Payments to other individuals for services received after the individual enters LTC are considered an uncompensated transfer for Medicaid purposes."[192]

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[190] Consider a services agreement in which payments are deferred with interest, and secured by a deed of trust on the home of the service recipient. While the tax implications are beyond the scope of this work, if property is transferred in consideration of services, income tax is generally due. IRC § 83. The IRS provides guidance in this connection with deferred compensation as follows: "Section 83 codifies the economic benefit doctrine in the employment context by providing that if property is transferred to a person as compensation for services, the service provider will be taxed at the time of receipt of the property if the property is either transferable or not subject to a substantial risk of forfeiture. If the property is not transferable and subject to a substantial risk of forfeiture, no income tax is incurred until it is not subject to a substantial risk of forfeiture or the property becomes transferable. For purposes of § 83, the term 'property' includes real and personal property other than money or an unfunded and unsecured promise to pay money in the future. However, the term also includes a beneficial interest in assets, including money, that are transferred or set aside from claims of the creditors of the transferor, for example, in a trust or escrow account. Property is subject to a substantial risk of forfeiture if the individual's right to the property is conditioned on the future performance of substantial services or on the nonperformance of services. In addition, a substantial risk of forfeiture exists if the right to the property is subject to a condition other than the performance of services and there is a substantial possibility that the property will be forfeited if the condition does not occur. Property is considered transferable if a person can transfer his or her interest in the property to anyone other than the transferor from whom the property was received. However, property is not considered transferable if the transferee's rights in the property are subject to a substantial risk of forfeiture." Nonqualified Deferred Compensation Audit Techniques Guide (06-2021). A retained power of appointment in the grantor of the deed of trust to secure the debt to a person other than the creditor (usually child providing services), the grantor, the grantor's creditors, etc., should create a substantial risk of forfeiture as to the property. A deferral of the right to exercise the creditor's rights until the real estate (if a residence) is no longer used as a residence should cause a deferral of income tax recognition until the condition (non-residence) occurs.

[191] Federal law requires no such statement or limitation. Would payments made to an assisted living facility or other private duty sitter be deemed to be a disqualifying transfer of assets because the payor would not have gone into nursing home care at the time the payments were made?

[192] Like countless other family members, the writer has employed privately paid "feeders," "sitters" and geriatric care managers for privately paying nursing home residents for whom he has served as fiduciary. Will these payments disqualify the residents from nursing home care under Medicaid? By what authority?

13. Divorce following transfer of assets to CS?

    a. Transfers between spouses are exempt.

    b. Divorce following transfer of assets from institutionalized spouse to community spouse severs the conduit (marriage) which imputes resources of the (former) community spouse to the institutionalized spouse.

        i. ***Caveat***: MMNA income support rules no longer applicable to the former community spouse.

        ii. Consider QDROS by which ownership of the income producing asset (pension) is itself transferred to the community spouse in the divorce decree.

14. Purchase of United States EE or I Bonds post-institutionalization ($20,000 limit per spouse, 12 month holding period)?[193]

15. Reverse Mortgage.[194]

    a. Reverse mortgage payments are not considered income for Medicaid purposes in the month of receipt and become a resource only to the extent retained in the next calendar month.[195]

        i. Payments from the home equity when title is vested in the CS will not alter the Monthly Maintenance Needs Allowance payments due from the IS.

        ii. Payments retained *by a community spouse **after** eligibility of the institutionalized spouse* is established will have no effect upon the continuing coverage of the institutionalized spouse.

    b. Reverse mortgage payments as means of "covering" DRA penalty periods.

III. Planning Considerations: Survivor Eligibility

A. When a benefactor (such as a spouse, parent, or other significant other in the life of a Medicaid or potential Medicaid recipient) dies and leaves to the Medicaid recipient, the assets will trigger disqualification and fund a source of Medicaid estate recovery.

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[193] See discussion above; Va. Medicaid Manual §M 1140.240 A.

[194] Va. Medicaid Manual § M 1120.225 B. See HUD Handbook 4000.1, published 10-31-2023, specifically providing that "[t]his update to the FHA Single Family Housing Policy Handbook, or Handbook 4000.1, is to incorporate guidance for FHA's Title II Insured HECM program." See Part B, Title II Insured Housing Programs Reverse Mortgages; the writer's 2014 entitlements oriented outline; and HECM Financial Assessment And Property Charge Guide Revised July 13, 2016.

[195] Va. Medicaid Manual §M 1120.225.

B. Advise likely benefactors (e.g., parents, unmarried siblings, adult children) to bypass spouse(s) or create special needs trust for spouse(s) in benefactor's estate plan.

C. In addition to the loss of eligibility, Virginia will recoup its Medicaid expenditures for benefits paid after the recipient's 55th birthday from whatever remains in the estate of the Medicaid beneficiary after death.[196] Example: Great uncle leaves niece, 65, $50,000 in his will. She has been on Medicaid for 9 years. She will lose eligibility, but dies 5 days after Uncle, before any distribution has been made to her. Medicaid is entitled to recover its claim for 9 years of payments from the gift Uncle made absent a posthumous disclaimer by niece's administrator.[197]

D. Benefactors other than spouses.

1. Any trust (either one created by will or during lifetime of the benefactor) in which the benefactor retains the use during life but creates a spendthrift, purely discretionary trust effective to supplement assets of the Medicaid beneficiary during life.

2. At death of Medicaid beneficiary, residue in trust will avoid estate recovery and pay to third parties (grandchildren, charities, etc.).

E. Spouse benefactors.

1. Because of the elective share rules applicable to spouses,[198] beware of both resource and transfer of assets issues.

2. **DO NOT USE** living trusts when one spouse is Medicaid eligible, or expected to be.[199]

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[196] Estate recovery for Medicaid recipient, 12 VAC 30-20-141(C) for past benefits paid (after age 55).

[197] There is no effective penalty for a posthumous disclaimer by the personal representative of a deceased Medicaid beneficiary. Virginia Code § 64.2-2603 B provides that "[e]xcept to the extent a fiduciary's right to disclaim is expressly restricted or limited by another statute of the Commonwealth or by the instrument creating the fiduciary relationship, a fiduciary may disclaim, in whole or in part, any interest in or power over property, including a power of appointment, whether acting in a personal or representative capacity."

[198] Va. Code § 64.2-300 et seq. As discussed below, elective share calculations for decedents dying on or after January 1, 2017, have become considerably more complex than under prior law. The elective share of a surviving spouse is a graduated percentage of the decedent's assets, taking into account both spouses' assets on a quasi-partnership theory, and the length of marriage. As of this publication, three Virginia cases have addressed Va. Code § 64.2-308.1 *et seq*. *Brown v. Brown, Adr*., 69 Va.App. 462 (Ct.App. Va. 2018) (in a bifurcated divorce proceeding, husband's death after divorce but before equitable distribution decree did not deprive court of jurisdiction to dispose of wife's equitable distribution claims, the Court "fail[ing] to see the equity" in the final order's termination of the elective share rights and, were jurisdiction not retained, any share in the "monetary fruits of the marriage."); *Thompson v. Administrator*, 103 Va. Cir. 170, 2019 WL 11838609 (2019)(unpublished circuit court opinion, court not specified) (widow did not abandon deceased husband, elective share in addition to exempt property, family allowance, or the homestead allowance); *Algabi v. Dagvadorj*, et al., 106 Va. Cir. 153, 2020 WL 10458186 (2020)(unpublished)(elective share not applicable when waived in pre-nuptial agreement);

[199] The short reason is that each spouse is a creator of the trust (Va. Medicaid Manual § M 1140.404 B 1a) and to the extent the corpus cannot be paid to the individual, the trust corpus is considered a transfer of assets, *Id.* b. See *Bezzini*, at 715 A.2d 791 (Conn. App., Jul 21, 1998). The analog – that a testamentary trust is not a transfer of assets by a spouse, and thus

3. Marital agreements waiving elective share.

   a. A surviving spouse married to a deceased Virginia spouse has a right to an elective share.

   b. An unanticipated elective share could disqualify the surviving spouse on Medicaid, or vest additional countable resources in the spouse.

   c. A well-crafted marital agreement is an enforceable contract based upon lawful consideration. [200]

   d. For decedents dying after 2016, the practice and use of marital agreements waiving the elective share has been clarified by providing that "the right of election of a surviving spouse and the rights of the surviving spouse to homestead allowance, exempt property, and family allowance, or any of them, may be waived, wholly or partially, before or after marriage, by a written contract, agreement, ***or*** waiver signed by the surviving spouse."[201]

      i. The General Assembly lists three instruments (contract, agreement, and waiver) by which a surviving spouse can forego the elective share.

      ii. An *agreement* or written contract between the spouses will be enforceable under ordinary contract law and in conformity with the Virginia Premarital Agreement Act, Virginia Code § 20-147 *et seq.*

      iii. The statute provides that a *waiver* will be enforced unless the surviving spouse proves the agreement was involuntary or unconscionable.[202]

4. Possible testamentary dispositions:

   a. Testamentary[203] special needs trust with mandatory income interest to satisfy the elective share requirement for survivor spouse in entire estate is available if it meets the following criteria:

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preferable in the planning process for the community spouse's estate – is discussed (and approved) in *Skindizer*, *infra*.

[200] Virginia Code § 20-155 provides that married persons " may enter into agreements with each other for the purpose of settling the rights and obligations of either or both of them, to the same extent, with the same effect, and subject to the same conditions, as provided in §§ 20-147 through 20-154 for agreements between prospective spouses, except that such marital agreements shall become effective immediately upon their execution." § 20-150 states that such an agreement may "contract with respect to … disposition of property upon separation, marital dissolution, death, or the occurrence or nonoccurrence of any other event."

[201] Virginia Code § 64.2-308.14.

[202] *Id.* (B) (2).

[203] *Skindzier*, at 784 A.2d 323 (Conn. 2001) (testamentary trust not disqualifying asset transfer).

b. In valuing … beneficial interests in trust [for the surviving spouse], the following special rules apply:

i. The value of the beneficial interest of a spouse shall be the entire fair market value of any property held in trust if the decedent was the settlor of the trust, if the trust is held for the exclusive benefit of the surviving spouse during the surviving spouse's lifetime, and if the terms of the trust meet the following requirements:

1. During the lifetime of the surviving spouse, the trust is controlled by the surviving spouse or one or more trustees who are non-adverse parties;[204]

2. The trustee shall distribute to or for the benefit of the surviving spouse the entire net income of the trust at least annually;

3. The trustee is permitted to distribute to or for the benefit of the surviving spouse out of the principal of the trust such amounts and at such times as the trustee, in its discretion, determines for the health, maintenance, and support of the surviving spouse; and

4. In exercising discretion, the trustee may be authorized ***or required*** to take into consideration all other income assets and other means of support available to the surviving spouse.[205]

c. As stated above, the risk of imputation of a disqualifying elective share for a surviving spouse who is an incapacitated person has been addressed by the statutes described above and below.

d. Testamentary special needs trusts with formula provision providing for the minimum elective share calculable pursuant to Article 1.1 with a disposition of the residue (to third parties or to a *purely discretionary* trust which need not meet the criteria stated above) remains available, as under former law.

e. The law calculates the elective share of the surviving spouse as a graduated percentage, taking into account both spouses' assets and the length of marriage.

f. For decedents dying after December 31, 2016, the surviving spouse of a Virginia domiciliary decedent may elect to take an elective-share amount equal to 50 percent of the value of the marital-property portion of the augmented estate.

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[204] The *spouse* should never be made the trustee because of the discretionary rights over principal. Moreover, because "[u]nder section [IRC] 672(a) an adverse party is defined as any person having a substantial beneficial interest in a trust which would be adversely affected by the exercise or nonexercise of a power which he possesses respecting the trust,"

26 CFR 1.672(a)-1 - *Definition of adverse party*, a remainder-person cannot serve because of the "substantial interest" he would have in making the determination of discretionary distributions.

[205] Va. Code § 64.2-308.9 (C)(2)(a).

i. There is a 2 step determination, being the (i) determination of the augmented estate and (ii) the marital property portion.

ii. Composition of the augmented estate, subject to certain exclusions,[206] is the sum of:

1. The decedent's net probate estate;
2. The decedent's non-probate transfers to others;
3. The decedent's non-probate transfers to the surviving spouse; and
4. The surviving spouse's property and non-probate transfers to others.[207]

iii. The marital property portion of the augmented estate depends upon the length of the marriage between the decedent and the surviving spouse in accordance with this table, and is the sum of the augmented estate constituent elements above multiplied by a percentage, which in turn is based upon the length of the marriage:[208]

1.	Less than 1 year	3%
2.	1 year but less than 2 years	6%
3.	2 years but less than 3 years	12%
4.	3 years but less than 4 years	18%
5.	4 years but less than 5 years	24%
6.	5 years but less than 6 years	30%
7.	6 years but less than 7 years	36%
8.	7 years but less than 8 years	42%
9.	8 years but less than 9 years	48%
10.	9 years but less than 10 years	54%
11.	10 years but less than 11 years	60%
12.	11 years but less than 12 years	68%
13.	12 years but less than 13 years	76%
14.	13 years but less than 14 years	84%
15.	14 years but less than 15 years	92%
16.	15 years or more	100%

[206] Virginia Code § 64.2-308.9.

[207] Virginia Code § 64.2-308.4 (A).

[208] Virginia Code § 64.2-308.4 (B).

g. The elective share right is personal to the surviving spouse,[209] with special provisions for incapacitated surviving spouses.[210]

i. When the election is made by a conservator or agent, the statute presumes the surviving spouse for whom the election is made an "incapacitated person."

ii. When a validly appointed and qualified conservator asserts the surviving spouse election, the surviving spouse is conclusively an incapacitated person.[211]

iii. When an *agent* asserts the election, the surviving spouse may not be an "incapacitated person."[212]

[209] Virginia Code § 64.2-308.13, Right of election personal to surviving spouse; incapacitated surviving spouse.

[210] *Id.*, (B). Throughout the Article, the Code refers to a surviving spouse who is an "incapacitated person."

[211] "'Conservator' means a person appointed by the court who is responsible for managing the estate and financial affairs of an incapacitated person." Va. Code § 64.2-2000.

[212] No definition exists for an "incapacitated spouse" in the elective share statutes. There is no separate definition for an "incapacitated person" in these statutes. However, while not defined in the elective share statutes, Chapter 20 of Title 64.2 *does* define "incapacitated person" to mean "an adult who has been found by a court to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential requirements for his health, care, safety, or therapeutic needs without the assistance or protection of a guardian or (ii) manage property or financial affairs or provide for his support or for the support of his legal dependents without the assistance or protection of a conservator."

If the predicate fact for the presumption requires a court adjudication, and none exists, will the presumption permit the Court to act under the aegis of Virginia Code § 64.2-308.13?

Another concern: 42 USC 1396p (d)(2)(A)(iv) provides that "an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will: … (iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse, or (iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse."

If the election is made pursuant Virginia Code § 64.2-308.13, the decedent spouse's assets should not be considered a transfer of assets by the surviving spouse because the assets *in* the estate of the deceased spouse did not vest in the surviving spouse. This foils imputation pursuant to 42 USC 1396p (d)(2)(A)(iv), which provides that "an individual shall be considered to have established a trust [only] if assets ***of the individual*** were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will: … (iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse, or (iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse."

h. For an incapacitated surviving spouse,[213] a court proceeding is necessary in order to create the trust specified in the statute for the surviving spouse's protection.[214]

i. If "the Court enters an order determining the amounts due to the surviving spouse," the court "must set aside that portion of the elective share amount due from the decedent's probate estate and recipients of the decedent's non-probate transfers to others under subsections C and D of § 64.2-308.10 and must appoint a trustee to administer that property for the support of the surviving spouse."

j. "The trustee must administer the trust in accordance with the following terms or such other terms as the court determines appropriate:

   i. Expenditures of income and principal may be made in the manner, when, and to the extent that the trustee determines suitable and proper for the surviving spouse's support, without court order but with regard to other support, income, and property of the surviving spouse and ***benefits of medical or other forms of assistance from any state or federal government or governmental agency for which the surviving spouse must qualify on the basis of need.***[215]

   ii. During the surviving spouse's incapacity, neither the surviving spouse nor anyone acting on behalf of the surviving spouse has a power to terminate the trust; but if the surviving spouse regains capacity, the surviving spouse then acquires the power to terminate the trust and acquire full ownership of the trust property free of trust.

   iii. Upon the surviving spouse's death, the trustee must transfer the unexpended trust property in the following order: (i) under the residuary clause, if any, of the will of the predeceased spouse against whom the elective share was taken, as if that predeceased spouse died immediately after the surviving spouse; or (ii) to the predeceased spouse's heirs under Chapter 2 (§ 64.2-200 et seq.).[216]

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[213] This includes any spouse for whom the election is made by an agent under a power of attorney, see Virginia Code § 64.2-308.13 (B), which specifies that "an election on behalf of a surviving spouse by a conservator or agent under a durable power of attorney is presumed to be on behalf of a surviving spouse who is an incapacitated person." *Caveat*: see footnote 177.

[214] Virginia Code § 64.2-308.12, -13 (A).

[215] ***Emphasis supplied*** by writer. The importance of this provision for incapacitated surviving spouses – including any spouse who chooses to act through a power of attorney to assert any such claim – is important in relation to the requirement that the court created trust must be considered a testamentary trust *of the first spouse to die*, Virginia Code § 64.2-308.13 (B)(4), and the exclusion of such trusts for transfer of assets purposes for failure of the surviving spouse to elect the elective share pursuant to the *policy* (inferior to the statute), Medicaid Manual § M 1450.003 (C).

[216] Clearly the assets remaining in the trust pass as a part of the residuary estate of the first spouse to die, avoiding surviving spouse creditors, Medicaid recovery pursuant to 42 USC 1396p, see 12VAC30-20-141, *Estate recoveries*.

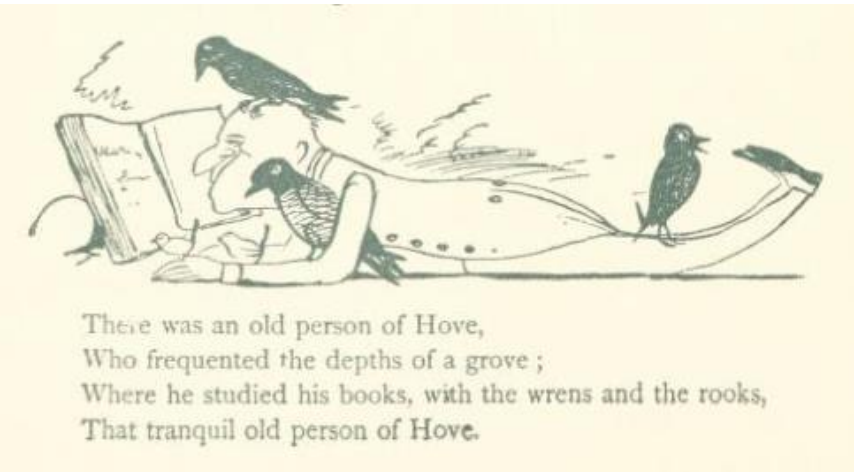

Image: A Book of Limericks, Lear, Edward, 1812-1888, p.42.

Exhibit A

Click [217]

Click

2024

SSI and Spousal Impoverishment Standards

Supplemental Security Income (SSI) *Effective 1-1-24*

	SSI Federal Benefit Rate (FBR)	SSI Resource Standard	Income Cap Limit (300%)	Earned Income Break Even Point	Unearned Income Break Even Point
Individual	943.00	2,000.00	2,829.00	1,971.00	963.00
Couple	1,415.00	3,000.00	N/A	2,915.00	1,435.00

Substantial Gainful Activity (SGA) Limit: 1,550.00 (Blind SGA: 2,590.00)

CPI Increase for 2024 3.7%
CPI Increase, Since September 1988: 156.9%

Spousal Impoverishment *Effective 1-1-24 Unless Otherwise Noted*

Minimum Monthly Maintenance Needs Allowance (MMMNA):	2,555.00	All States (Except Alaska and Hawaii)
(Effective 7-1-24)	3,192.50	Alaska
	2,937.50	Hawaii
Maximum Monthly Maintenance Needs Allowance:	3,853.50	
Community Spouse Monthly Housing Allowance:	766.50	All States (Except Alaska and Hawaii)
(Effective 7-1-24)	957.75	Alaska
	881.25	Hawaii
Community Spouse Resources:		
Minimum Resource Standard:	30,828.00	
Maximum Resource Standard	154,140.00	
Home Equity Limits:		
Minimum:	713,000.00	
Maximum:	1,071,000.00	

[217] Credit *Einstein on the Beach* at YouTube, copyright by Philip Glass. The tiny excerpt is believed to be fair use, very fresh and clean, and known to be helpful for understanding this complex area of the law.

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Bobzien-Gaither Educational Center in Richmond, Virginia
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Synergy of Special Needs Trusts and ABLE Accounts

I. What are Special Needs Trusts (SNTs):

Special needs trusts (SNTs), also known as supplemental needs trusts, are legal arrangements designed to provide financial support and care for individuals with disabilities or special needs. Understanding these trusts can empower individuals with disabilities, giving them a sense of control and confidence in their financial future. *See* POMS: SI 01120.200. These trusts are intended to supplement government benefits such as Medicaid and Supplemental Security Income (SSI) rather than replace them. *Id.* The primary goal of a special needs trust is to enhance the quality of life for the individual while preserving their eligibility for government benefits. *Id.*

A. **Preservation of Benefits Eligibility**: SNTs are structured so that the assets held within the trust do not count against the beneficiary's eligibility for means-tested government benefits such as Medicaid and SSI.

B. **Protection of Assets**: Assets placed into a special needs trust are protected from being spent down for the beneficiary's care, ensuring that they will be available to provide for the beneficiary's needs throughout their lifetime. The assets are protected from creditors and predators while in the SNT.

C. **Supplemental Support**: The funds in a special needs trust can be used to provide supplemental support for the beneficiary's needs that are not covered by government benefits. This can include expenses related to education, transportation, recreation, medical and dental care not covered by Medicaid, personal care attendants, therapies, and more.

D. **Managed by a Trustee**: A trustee is appointed to manage the trust assets and make distributions according to the trust document's terms. The trustee has a fiduciary duty to act in the beneficiary's best interests.

E. **Flexibility**: Special needs trusts can be structured in various ways to suit the needs of the beneficiary and their family. They can be funded during the grantor's lifetime (the person establishing the trust) or through a testamentary provision in a will.

F. **Third-party Trusts vs. First-party Trusts**: Special needs trusts can be categorized as third-party trusts (established by someone other than the beneficiary) or first-party trusts

(established with the beneficiary's own assets, typically in situations where the individual receives a settlement or inheritance). The rules and regulations governing these trusts can vary, so it's important to understand the differences.

1) Third-Party SNTs. *See* POMS SI 01120.203
   - No law specifically on Third-Party SNTs. Review the Program Operations Manual System (POMS) SI 01120.200 on Trusts.
   - Can be revocable or irrevocable.
   - These trusts can be *inter vivos* or testamentary.
   - In general, the terms may be less restrictive as those in 1st-party Special Needs Trusts.

2) 1st-Party SNTs. *See* POMS SI 01120.203
   - The law regarding 1st party Special Needs Trusts is found at 42 USC §1396p(d)(4)(A) and 1st party pooled Special Needs Trusts are at (d)(4)(C).
   - These trusts are established with the assets of an individual with disabilities. The individual must be under the age of 65 at the time the trust is established and funded. The individual must be disabled as defined in the Social Security Act.
   - The 1st party Special Needs Trust may be established by a parent, grandparent, legal guardian, the court, and now, the competent individual with disabilities.
   - With respect to Social Security reviewing these trusts, in this area, the trusts must be "seeded" by the $10.00 language we put into the trust.
   - Review of the POMS SI 01120.200 on Trusts is essential.

G. **Pooled Special Needs Trusts**: The law for pooled trusts is under 42 U.S.C. §1396p(d)(4)(C). A non-profit association must administer pooled trusts. These trusts can be first-party or third-party. The trust assets are pooled for investment purposes (similar to a bank). Each beneficiary has his or her own separate account, but the non-profit administers the trust for multiple beneficiaries. Lower set-up costs and administration costs. Oftentimes, the pooled trusts receive better investment returns from a relatively low-valued stand-alone SNT. Useful option for limited assets.

H. **Pooled vs. Standalone Trusts.**

Pros of Pooled Trusts	**Pros of Standalone Trusts**
A more affordable and economical option than establishing a separate standalone trust	May give the beneficiary more financial independence (if warranted)
It removes concerns on finding a qualified and appropriate trustee	Can hold real estate*

Managed by a nonprofit organization	Can provide for any specific nuances particular to the individual beneficiary (more flexibility)
The staff of the pooled trusts are experts in the area of public benefits	
In most cases, the pooled trust may have better investment returns because all the assets are pooled for purposes of investments	*Be sure to check with the pooled trust before setting it up to see if it accepts real estate.

Cons of Pooled Trusts	**Cons of Standalone Trusts**
Not all pooled trusts allow for tailored investment strategies	Difficulty or inability to identify an appropriate trustee
The pooled trust will advocate for the family to leave any money remaining (after payback to Medicaid on first-party SNTs and after administrative costs in terms of the third-party trusts)	Costs to set-up the trust and the annual/administrative fees tend to be much higher than the pooled trusts
Funds for large disbursements may not be readily available to the beneficiary. Payments to providers must be requested and justified as reasonable and necessary. For things like routine medical expenses, the pooled trust company will arrange for these to be automatic	
Some pooled trusts will not accept real property or accept real property with a minimum of cash	

Both pooled and standalone SNTS provide creditor protection to the beneficiary. Retirement accounts can be stretched to the beneficiary's life expectancy rather than the 10-year limit (see below). Others can easily make gifts to a third-party SNT.

II. What are ABLE Accounts:

ABLE accounts, or Achieving a Better Life Experience accounts, are tax-advantaged savings accounts created to assist individuals with disabilities and their families in saving and investing funds for disability-related expenses. Established through the Stephen Beck Jr. Achieving a Better Life Experience Act in 2014, ABLE accounts aim to safeguard eligibility for means-tested government benefits like Medicaid and Supplemental Security Income (SSI). Modeled after Section 529-C college savings accounts, ABLE accounts are governed by rules outlined in Social Security's Program Operations Manual Services (POMS) at SI 01130.740. Here are the key features of ABLE accounts:

- **Tax Advantages**: The tax advantages of ABLE accounts are akin to Roth IRAs: contributions are made with after-tax dollars, and earnings grow tax-free within the account. Additionally, withdrawals are tax-free if **used** for *qualified disability expenses*. However, using funds for non-qualified expenses incurs penalties, much like withdrawing from a Roth IRA before retirement age. For instance, if a disabled individual accumulates $50,000 over a decade with $10,000 in earnings, totaling $60,000 in his ABLE account, he incurs no taxes if he uses it for a home down payment. However, if he spends $5,000 on a non-qualified expense, like gambling in Atlantic City, he faces taxation plus a 10% penalty.

- **Eligibility Requirements**: To be eligible for an ABLE account, the individual must have become disabled before turning 26 and meet Social Security Administration's criteria for disability, including SSI or SSDI eligibility or blindness. An eligible individual can qualify for an ABLE account through the following means:

    i) Disability can be established by meeting the criteria for SSI or SSDI benefits, or
    ii) By obtaining a doctor's certification equivalent to the Social Security's definition of disability.
    iii) The individual must be diagnosed with a disability before turning 26.
    iv) This requirement will change in 2026, shifting to a disability onset before the age of 46.

    Note: Remember that you cannot use a doctor's certification to secure Medicaid or Social Security benefits – the doctor's certification is not a shortcut to public benefits! It is only an option to obtain eligibility for an ABLE account (if you don't receive SSD or SSI but meet Social Security's disability definition).

- **Limits and Options:**

    A. Contribution Limits

    i) Each state offering ABLE accounts sets its contribution limit, typically linked to the federal gift tax exclusion ($18,000 as of 2024).
    ii) Some states impose an overall maximum account balance limit. Virginia has a $550,000.00 maximum account balance limit.
    iii) Contributions into an ABLE account may be made by any person, including a trust like a Special Needs Trust.
    iv) Contributions to the ABLE account are not tax-deductible, but income earned within the account is tax-free if used for Qualified Disability Expenses.
    v) Contributions must be made in cash; real property, retirement accounts, stocks, and bonds are not permitted.

    B. Additional Contribution Option:

    Employed individuals with disabilities may make additional contributions, capped at either their annual compensation or the poverty line for a one-person household ($15,060 in 2024), whichever is less.

C. Savers Credit Eligibility:
   i) ABLE account holders may be eligible for the Savers Credit, a non-refundable tax credit of up to $1,000.
   ii) Eligibility criteria include being at least 18 years old, not being a dependent or full-time student, and meeting income requirements.

D. Individuals are limited to one ABLE account only.

E. Some states allow their own residents a deduction for contributions to their ABLE accounts. Virginia offers up to $2,000.

F. Qualified Disability Expenses**:** Funds in an ABLE account can be used for a variety of disability-related expenses approved by the IRS. These include:

Education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention, and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses, basic living expenses.

G. Ownership and Control**:** In an ABLE account, the individual with the disability is the designated account owner. However, if the individual is unable to manage the account independently, a designated person, often a parent, guardian, or agent under power of attorney may establish and oversee the account on their behalf.

III. **Impact on Benefits**:

Funds held in ABLE accounts generally do not count against resource limits for means-tested benefits such as SSI and Medicaid, up to certain thresholds.

a. SSI Eligibility:
   - The first $100,000 in the ABLE account is typically excluded from being counted as a resource for SSI.
   - Most account withdrawals for Qualified Disability Expenses are also excluded.
   - SSI payments may be suspended if the account balance exceeds $100,000.

b. Medicaid Eligibility:
   - ABLE account balances and withdrawals are completely excluded assets for Medicaid purposes up to the state's limit for Section 529-C accounts.

c. Impact on Benefits:
   - Exceeding $100,000 in ABLE account funds for SSI leads to the suspension of benefits, but the individual's Medicaid could remain until it reaches the state's limit.
   - Upon the beneficiary's passing, remaining ABLE account assets can be used to settle outstanding Qualified Disability Expenses and funeral/burial expenses before any funds are reimbursed to Medicaid.

d. State-Specific Programs: ABLE accounts are managed at the state level, and each state may offer its own program with unique features, investment options, and fee structures. Individuals can open an ABLE account in any state that provides them, regardless of their state of residence. Virginia no longer requires a Medicaid payback at the owner's death.

IV. In-Kind Support & Maintenance Issue for Recipients of SSI

1) SSI covers basic shelter needs. If someone else, such as a parent or a Special Needs Trust (SNT), pays the rent directly for an SSI recipient, it's considered In-Kind Support and Maintenance (ISM). This usually results in reduced SSI payment, typically by one-third (Value of One-Third or VTR).

2) Specifically, if a family member or an SNT pays rent for an SSI recipient, the recipient's monthly SSI payment is reduced dollar for dollar, capped at the Presumed Maximum Value (PMV), which is one-third and $20.

3) The Social Security Administration recently clarified that distributions from an ABLE account, whether for housing or non-housing Qualified Disability Expenses (QDEs), are not counted as income.

4) Consequently, distributions from an ABLE account for housing-related QDEs do not reduce the SSI payment.

5) With an ABLE Account, a parent or an SNT can deposit rent funds into the account, and the ABLE account can then distribute the payment for rent without affecting the SSI payment.

6) Normal SSI resource counting rules and exclusions apply to any assets purchased with funds from an ABLE Account.

V. Addressing Common Concerns and Pitfalls:

1. Funding and Contribution Limits

- **Special Needs Trust (SNT):**
  - *Pitfall:* SNTs do not have contribution limits, which can be advantageous for significant financial resources.
  - *Concern:* However, establishing and managing an SNT can be costly and complex, especially if it requires court involvement or a professional trustee.
- **ABLE Account:**
  - *Pitfall:* ABLE accounts have annual contribution limits, currently capped at $18,000 (as of 2024). This limit can restrict the amount of money that can be sheltered in the account in any given year.
  - *Conflict:* If the individual receives substantial gifts or inheritances, an ABLE account alone may be insufficient.

2. Use of Funds

- **SNT:**
  - *Concern:* The rules governing the use of SNT funds can be restrictive, particularly for first-party SNTs, which must be used for the sole benefit of the disabled individual.
  - *Conflict:* There can be disagreements or misunderstandings about what constitutes an allowable expense, leading to conflicts between trustees and beneficiaries.
- **ABLE Account:**
  - *Pitfall:* ABLE accounts have more flexibility regarding what the funds can be used for (Qualified Disability Expenses, or QDEs), but misuse of funds could result in tax penalties and loss of benefits. The debit card associated with the ABLE account could be stolen.
  - *Concern:* Some expenses may not qualify as QDEs, creating potential tax liabilities or even disqualification of the account.

3. Medicaid Payback. *See* POMS SI 01120.203.

- **SNT:**
  - *Concern:* First-party SNTs are subject to Medicaid payback upon the beneficiary's death, meaning that any remaining funds must be used to reimburse Medicaid for services provided during the beneficiary's lifetime.
  - *Conflict:* Families may be concerned about losing assets to Medicaid rather than passing them to other heirs.
- **ABLE Account:**
  - *Concern:* ABLE accounts are also subject to Medicaid payback upon the beneficiary's death, which may surprise some families who incorrectly believe the account is exempt from such claims. Although less of a concern these days as many states have followed Virginia's lead into removing the payback requirement.
  - *Pitfall:* This can result in a significant reduction in the amount left to heirs.

4. Impact on Benefits

- **SNT:**
  - *Concern:* Properly structured SNTs do not affect eligibility for means-tested benefits like Supplemental Security Income (SSI) or Medicaid.
  - *Pitfall:* Poorly drafted or managed trusts may inadvertently disqualify a beneficiary from these benefits.
- **ABLE Account:**
  - *Concern:* Funds in an ABLE account up to $100,000 are exempt from SSI asset limits, but exceeding this threshold could result in a temporary suspension of SSI benefits.
  - *Conflict:* Managing the balance in an ABLE account requires careful planning to avoid negative impacts on SSI.

5. Management and Control

- **SNT:**
  - *Concern:* SNTs often require a trustee to manage the funds, which can create a power imbalance and potential conflicts between the trustee and the beneficiary.
  - *Pitfall:* Beneficiaries might feel a lack of control over their resources, leading to dissatisfaction or disputes.
- **ABLE Account:**
  - *Concern:* ABLE accounts are typically managed by the beneficiary (or an authorized representative), providing more control but also more responsibility.
  - *Pitfall:* Mismanagement by the beneficiary could lead to misuse of funds and potential disqualification from benefits.

6. Costs and Complexity

- **SNT:**
  - *Concern:* Establishing and maintaining an SNT can be expensive, especially if it involves legal fees, trustee fees, and annual reporting requirements.
  - *Pitfall:* Complexity in trust management can lead to mistakes or oversights that may have legal or financial consequences.
- **ABLE Account:**
  - *Concern:* ABLE accounts are generally less expensive and simpler to set up and maintain, but they offer fewer protections and less flexibility than SNTs.
  - *Pitfall:* The simplicity of ABLE accounts may lead families to overlook more comprehensive planning needs that an SNT could address.

7. State-Specific Considerations

- **SNT:**
  - *Concern:* SNTs are governed by state-specific trust laws, which can vary widely, potentially complicating interstate issues or moves.
- **ABLE Account:**
  - *Concern:* ABLE accounts are also state-specific, with some states offering better programs than others. Not all states offer ABLE accounts, though residents can use another state's program.
  - *Conflict:* Beneficiaries may need to navigate differences in state laws if they relocate.

VI. Case Study: Irene’s Housing and Financial Support:

Background:

Irene is a 28-year-old adult with a disability who receives Supplemental Security Income (SSI) benefits. She lives independently in an apartment that costs $900 per month. Her SSI benefit is $914 monthly (the federal maximum in 2024).

Irene's father, Mr. Johnson, wants to help her financially by paying her rent directly.

Problem:
If Mr. Johnson directly pays Irene's rent, the SSI program considers this "in-kind support and maintenance" (ISM). As a result, Irene's SSI benefits would be reduced by one-third. This would decrease her monthly SSI payment by approximately $304.67, making managing her other living expenses harder.

Solution Using an ABLE Account and Special Needs Trust:

Step 1: Establish an ABLE Account
Mr. Johnson opened an ABLE account for Irene and contributed $900 each month, which is within the annual contribution limit.

The funds in the ABLE account can be used for Qualified Disability Expenses (QDEs), including housing, without affecting her SSI benefits up to a certain balance ($100,000).

Step 2: Paying Rent Through the ABLE Account
Instead of Mr. Johnson paying the rent directly, Irene uses the funds from her ABLE account to pay the $900 rent each month. Since this is considered Irene’s own money, there is no reduction in her SSI benefits.

Step 3: Establish a Special Needs Trust (SNT) for Additional Support
Mr. Johnson also establishes a third-party SNT for Irene, which can hold additional funds that exceed the ABLE account's contribution or balance limits.

The SNT can be used to cover Irene’s larger expenses, such as purchasing a vehicle or paying for a vacation.

Outcome:
By using the ABLE account to cover housing costs, Irene retains her full SSI benefit while paying her rent. This approach provides her with financial security and preserves her access to means-tested benefits.

The SNT offers additional financial protection, allowing Mr. Johnson to contribute larger amounts of money without worrying about the annual ABLE account contribution limits or the risk of disqualification from benefits.

This combination gives Irene more control over her daily finances while safeguarding her long-term needs.

Practical Implications:
Financial Security: Maintaining her full SSI benefits while covering essential expenses like rent through the ABLE account enhances Irene's economic security.
Flexibility: The SNT provides flexibility for more significant, less frequent expenses that might arise, ensuring Irene's needs are met without jeopardizing her benefits.

Peace of Mind: Thanks to the proper use of these financial tools, Mr. Johnson can contribute to Irene's well-being without worrying about inadvertently reducing her benefits.

VII. Future Developments and Considerations:

Updates on legislative and regulatory changes affecting Special Needs Trusts and ABLE accounts.

1. Changes Under the SECURE Act 2.0

The SECURE Act 2.0, enacted in 2023, introduced several changes that impact SNTs, particularly in relation to retirement accounts. Key updates include:

- **Required Minimum Distributions (RMDs):** The age for RMDs from retirement accounts has increased to 73 (starting in 2023) and will rise to 75 by 2033. This change allows for a longer period of tax-deferred growth, which can benefit SNTs designed to receive these distributions.
- **Eligible Designated Beneficiary Status:** The act clarifies that beneficiaries of SNTs can still be treated as "eligible designated beneficiaries," allowing for the stretch of RMDs over their lifetime, rather than requiring distributions within 10 years. This can provide more financial stability for beneficiaries.
- **Charitable Remainder Beneficiaries:** A provision in SECURE Act 2.0 allows a charitable organization to be a remainder beneficiary of an SNT without disqualifying the trust from benefiting a disabled individual under the favorable distribution rules.
-

2. SSI In-Kind Support and Maintenance (ISM) Rules

Starting on September 30, 2024, changes to the Social Security Administration's rules on ISM will exclude food from being considered as in-kind support when calculating SSI benefits. This could result in higher SSI payments for individuals receiving help with food costs, as these contributions will no longer reduce their benefits. Additionally, potential expansions in how rental subsidies are treated could further protect SSI recipients from reduced benefits due to assistance from family or friends.

3. Older ABLE Legislation Often Forgotten

- **ABLE to Work Act (H.R. 1896):** This bill allows working individuals to contribute more to their ABLE accounts beyond the standard annual limit, helping to encourage employment among people with disabilities.

- **ABLE Financial Planning Act (H.R. 1897):** This legislation allows families to roll over funds from 529 college savings plans into ABLE accounts without tax penalties, providing more flexibility in managing financial resources for individuals with disabilities. Remember, it is still limited to the annual contribution limit.

ADVANCED ELDER LAW SEMINAR
September 12, 2024

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Family Law Issues in Elder Law

I. Divorce

i. General Requirements

1. Grounds for divorce – Va. Code Ann §20-91
   a. Adultery
   b. Conviction of a Felony
   c. Cruelty
   d. Desertion/abandonment
   e. One year separation ***or*** six months separation **and** written agreement **and** no minor children of the marriage

2. Jurisdiction/residence – one party must be a resident & domiciliary of Virginia for at least six (6) months preceding the filing of the suit. Va. Code Ann §20-97

3. Legal Process
   a. Filing of Complaint for Divorce
   b. Service upon Defendant ***or*** Acceptance of Service via Answer or Acceptance & Waiver of Service
   c. Proof of grounds for divorce
      i. Must have corroboration for fault-based divorce
      ii. For no fault divorce, evidence may be provided via affidavit, written deposition, or *ore tenus* testimony

ii. Capacity Issues

1. *Andrews v. Creacy*, 56 Va. App. 606 (2010) held that, although Husband was found incapacitated and had a guardian and conservator, court found that he had the capacity to form the intention to separate.

2. *Hooker v. Hooker*, 215 Va. 415 (1975) recognizing that one party's incapacity is not a bar to obtain a divorce.

nor shall it be a bar that either party has been adjudged insane, either before or after such separation has commenced, but at the expiration of two years from the commencement of such separation, the grounds for divorce shall be deemed to be complete.

3. How to deal with an incapacitated spouse
   a. Appointment of Guardian *ad litem* subject to Va. Code Ann §8.01-9(1950)

b. Virginia requires the guardian to get court approval to change marital status pursuant to Va. Code Ann. §64.2-2019(D) (1950):

A guardian shall be required to seek prior court authorization to change the incapacitated person's residence to another state, to terminate or consent to a termination of the person's parental rights, or to initiate a change in the person's marital status.

c. Controversy surrounds whether a durable general power of attorney with specific authority can be used in court to pursue a divorce.

Heu v. Kim 107 Va. Cir. 100*, 2021 Va. Cir. LEXIS 7– Husband, through agent under a power of attorney, filed for divorce from his wife. Circuit Court of Fairfax required Husband to have a guardian rather than agent under POA. Interestingly, court held "power of attorney agents may not maintain divorce litigation on behalf of their principals where the document establishing the power of attorney does not expressly grant the authority to do so." The question of whether an agent could maintain a divorce action if expressly authorized to do so in the POA remains unanswered.

iii. Medicaid Divorce

1. A Medicaid divorce is the dissolution of a marriage where one spouse requires long-term care Medicaid. It is intended to protect assets for the community spouse. By divorcing, a community spouse may receive a greater portion of the couple's assets, protecting assets for the non-applicant spouse, and lowering the countable assets of the applicant spouse. Some couples may feel that this is the only plausible solution when one spouse requires long-term care.

2. Subject to the same requirements as any divorce

3. Marital Settlement Agreements are recognized by the Medicaid manual, but in general divorce must be finalized in order for institutionalized spouse to be eligible

4. Consider whether a 1st party or 3rd party Special Needs Trust can be utilized for institutionalized spouse, but generally must be done on a handshake basis

iv. Divorce and the Special Needs Child: When there is a special needs child, issues of custody, visitation, property division, and support are more complex.

1. Child support charts and guidance do not address the extra expenses of a child with special needs, including but not limited to specialty medical care, services, and equipment, medical treatments vitamins and nutritional needs.

2. Additionally, divorce agreements may have to deal with issues of a child's transition into adulthood; *for example*, guardianship, eligibility for government or private agency benefits, employment, social skills, independent living, custodial care, and recreation. Parents of special needs

children must consider co-parenting for the lifetime of the child, rather than the typical landmarks of attaining 18 years of age or graduating from college.

3. The full-time care of a special needs child may also affect the custodial parent's earning potential, so should be considered in spousal maintenance.

4. Another aspect of divorce planning may be splitting fees for establishing a SNT.

5. Clients should consider increasing life insurance coverage to help cover the costs of supporting a special needs child if one spouse predeceases the other prematurely.

b. Child Support and Public Benefits Issues for Divorcing Spouses with Special Needs Child(ren)

i. Child Support is treated as Income (POMS at SI 00830.420 (B) and SI 00830.420(C) and (D))

1. Treatment of child support payments made on behalf of an SSI minor child:

a. When an eligible child receives child support payments (including arrearage payments), the payments are unearned income to the child. For information on an SSI child, see SI 00501.010. **Practice Tip: Child support continues to be unearned income to the child in situations where the child and the parent, to whom the support is paid to, no longer live in the same household.**

b. When an absent parent makes a child support payment for an eligible child, exclude one-third of the amount. This exclusion does not apply when determining the income of ineligible children in a deeming computation.

c. *Food or shelter received as in-kind child support: Exclude one-third of the amount of child support that an eligible child receives in the form of food or shelter from an absent parent as income. The remaining two-thirds are in-kind support and maintenance (ISM) subject to the presumed maximum value (PMV).*

d. Any in-kind child-support payment that is not for food or shelter (e.g., for health insurance) is not income to the child.

e. When it comes to the treatment of income from specific "deemors," exclude the income used by an ineligible spouse, ineligible parent, ineligible child, or eligible alien to make court-ordered or Title IV-D support payments. Deduct the court-ordered or Title IV-D support payments from the parent's income prior to deeming by selecting deductions on the parent's applicable Income Selection page (e.g., Child Support page) and enter the amount of the support on the page. The system deducts the support amount from the ineligible parent's countable

income.

2. Treatment of child support payments made on behalf of an SSI adult child:
    a. When a parent or other person receives current child support payments for an adult child after the adult child stops meeting the definition of a child, the income belongs to the adult child. The support payments are income to the adult child even if he or she does not live with or receive any of the child support payment from the parent or other person. Such support payments are not subject to the SSI one-third child support exclusion.
    b. When a parent or other person receives current child support payments on behalf of a deceased SSI adult child, consider it income to the parent or other person who receives the payments. Support payments are not subject to the SSI one-third child support exclusion.
3. Tools to assign child support income
    a. Child support payments, treated as income, may result in disqualification from SSI unless the proper tools are utilized.
    b. Whether the assignment is treated as income depends on whether the assignment is revocable or irrevocable.
        i. A legally assignable payment that is assigned to a trust or trustee is income for SSI purposes, to the individual entitled or eligible to receive the payment, **unless the assignment is irrevocable**. SS considers assignment of payment by court orders to be irrevocable.
            1. For example, child support or alimony payments paid directly to a trust or trustee because of a court order are considered irrevocably assigned and thus not income.
            2. Further, U.S. Military Survivor Benefit Plan (SBP) payments assigned to a special needs trust are not income because the assignment of an SPB annuity is irrevocable.
                a. For more information on SPB annuities, see SI 01120.201J.1.e.
                b. See the "Memorandum for Deputy Assistant Secretary of the Army for Human Resources" dated 12/31/2015 from the Office of the Assistant Secretary of Defense; or DoD Instruction 1332.42 Survivor Benefit Plan.
        ii. If the assignment is revocable, the payment is income to the individual legally entitled or eligible to receive

it, unless an SSI income exclusion applies.

1. For **non-assignable payments**, see SI 01120.200G.1.c.

4. To ensure that the child support for a child on SSI does not result in an income disqualification for SSI, the following tools are available as long as the child support has been ordered (see POMS SI1120.200(G)(1)(d)):
    a. Utilize an SNT, as long as the parent or grandparent establishing the trust "seeds" it first by using a nominal amount of his or her own money as the first asset.
    b. Deposit the income to the designated beneficiary of an ABLE account.
5. Ongoing child support for disabled child (Va. Code Ann. §20-124.2(C) (1950)).
    a. The court may order that support be paid for any child of the parties. Upon request of either party, the court may order that such support payments be made to a special needs trust or an ABLE savings trust account as defined in Va. Code Ann §23.1-700 et. seq. The court shall also order that support will continue to be paid for any child over the age of 18 who is (i) a full-time high school student, (ii) not self-supporting, and (iii) living in the home of the party seeking or receiving child support until such child reaches the age of 19 or graduates from high school, whichever first occurs. The court may also order that support be paid or continue to be paid for any child over the age of 18 who is (a) severely and permanently mentally or physically disabled, and such disability existed prior to the child reaching the age of 18 or the age of 19 if the child met the requirements of clauses (i), (ii), and (iii); (b) unable to live independently and support himself; and (c) residing in the home of the parent seeking or receiving child support. In addition, the court may confirm a stipulation or agreement of the parties which extends a support obligation beyond when it would otherwise terminate as provided by law. The court shall have no authority to decree support of children payable by the estate of a deceased party. The court may make such further decree as it shall deem expedient concerning support of the minor children, including an order that either party or both parties provide health care coverage or cash medical support, or both.
    b. *Gaissert v. Gaissert*, 2016 Va. App. LEXIS 224 (2016)– Parties divorced after their son had reached age 18. They had previously filed a Petition for Guardianship as co-petitioners, which was awarded. The order appointing them as co-guardians contains numerous findings of fact

regarding their adult son's disability. Husband's previous status as co-petitioner in guardianship case was sufficient to determine adult child's need for ongoing child support.

c. *Rinaldi v. Dumsick*, 32 Va. App. 330, 528 S.E.2d 134 (2000) – adult child had cerebral palsy and was able to work part-time at Giant. He had cognitive impairments and deficits. He attended vocational training and worked less than 10 hours per week at a grocery store. He was receiving Social Security disability benefits. Mother presented evidence from his pediatrician and a career and transition expert from the school. Father claimed that because he was able to work, he did not qualify for ongoing child support. Court found that the fact that he was able to work part-time did not preclude a finding he was disabled and in need of ongoing child support.

d. May require a new child support order – See 20-108 regarding modification of child support orders

c. Spousal Support

i. Disability as material change of circumstances

ii. What if spousal support is non-modifiable?

iii. Payment of Spousal Support to a trust

FAMILY LAW ISSUES IN ELDER LAW

Advanced Elder Law Seminar

September 12, 2024

DIVORCE

General Requirements

- Grounds for Divorce
- Jurisdiction/Residence
- Legal Process

DIVORCE

Divorce

Capacity Issues

- *Andrews v. Creacy*, 56 Va. App. 606 (2010) held that, although Husband was found incapacitated and had a guardian and conservator, court found that he had the capacity to form the intention to separate.
- One party's incapacity is not a bar to obtain a divorce
- How to deal with an incapacitated spouse
  - Appointment of Guardian ad Litem subject to Va. Code Ann §8.01-9 (1950)
  - Authority of the Guardian
  - Agent under Power of Attorney

DIVORCE

Medicaid Divorce

- Subject to the same requirements as any divorce – not specifically recognized under Virginia Law
- Marital Settlement Agreements are recognized by the Medicaid manual, but in general divorce must be finalized in order for institutionalized spouse to be eligible
- Consider whether a 1st party or 3rd party Special Needs Trust can be utilized for institutionalized spouse, but generally must be done on a handshake basis

DIVORCE

Divorce and the Special Needs Child

- When there is a special needs child, issues of custody, visitation, property division, and support are more complex.
    - Child support charts and guidance do not address the extra expenses of a child with special needs, including but not limited to specialty medical care, services, and equipment, medical treatments vitamins and nutritional needs.
    - Additionally, divorce agreements may have to deal with issues of a child's transition into adulthood; *for example*, guardianship, eligibility for government or private agency benefits, employment, social skills, independent living, custodial care, and recreation. Parents of special needs children must consider co-parenting for the lifetime of the child, rather than the typical landmarks of attaining 18 years of age or graduating from college.
    - The full-time care of a special needs child may also affect the custodial parent's earning potential, so should be considered in spousal maintenance.
    - Another aspect of divorce planning may be splitting fees for establishing a SNT.
    - It must also be decided who will cover costs for filing for legal guardianship when the child turns 18 (if necessary).
    - Clients should consider increasing life insurance coverage to help cover the costs of supporting a special needs child if one spouse predeceases the other prematurely.

SPECIAL NEEDS AND CHILD SUPPORT

Child Support and Public Benefits Issues for Divorcing Spouses With Special Needs Child(ren)
Child Support is treated as Income (POMS at SI 00830.420 (B) and SI 00830.420(C) and (D))

Eligible child receives child support payments (including arrearage payments), the payments are unearned income to the child. **Practice Tip: Child support continues to be unearned income to the child in situations where the child and the parent, to whom the support is paid to, no longer live in the same household.**

Absent parent makes a child support payment for an eligible child, exclude one-third of the amount. This exclusion does not apply when determining the income of ineligible children in a deeming computation.

Food or shelter received as in-kind child support: Exclude one-third of the amount of child support that an eligible child receives in the form of food or shelter from an absent parent as income. The remaining two-thirds are in-kind support and maintenance (ISM) subject to the presumed maximum value (PMV). Any in-kind child-support payment that is not for food or shelter (e.g., for health insurance) is not income to the child.

SPECIAL NEEDS AND CHILD SUPPORT

Child Support and Public Benefits Issues for Divorcing Spouses With Special Needs Child(ren), continued

Treatment of child support payments made on behalf of an SSI adult child:

- When a parent or other person receives current child support payments for an adult child after the adult child stops meeting the definition of a child, the income belongs to the adult child. The support payments are income to the adult child even if he or she does not live with or receive any of the child support payment from the parent or other person. Such support payments are not subject to the SSI one-third child support exclusion.

- When a parent or other person receives current child support payments on behalf of a deceased SSI adult child, consider it income to the parent or other person who receives the payments. Support payments are not subject to the SSI one-third child support exclusion.

SPECIAL NEEDS AND CHILD SUPPORT

Child Support and Public Benefits Issues for Divorcing Spouses With Special Needs Child(ren), continued

- Whether the assignment is treated as income depends on whether the assignment is revocable or irrevocable.
  - A legally assignable payment that is assigned to a trust or trustee is income for SSI purposes, to the individual entitled or eligible to receive the payment, **unless the assignment is irrevocable**. SS considers assignment of payment by court orders to be irrevocable.
    - For example, child support or alimony payments paid directly to a trust or trustee because of a court order are considered irrevocably assigned and thus not income. Further, U.S. Military Survivor Benefit Plan (SBP) payments assigned to a special needs trust are not income because the assignment of an SPB annuity is irrevocable.
      - For more information on SPB annuities, see SI 01120.201J.1.e.
  - If the assignment is revocable, the payment is income to the individual legally entitled or eligible to receive it, unless an SSI income exclusion applies.
    - For **non-assignable payments**, see SI 01120.200G.1.c.

SPECIAL NEEDS AND CHILD SUPPORT

Child Support and Public Benefits Issues for Divorcing Spouses With Special Needs Child(ren), continued:

- To ensure that the child support for a child on SSI does not result in an income qualification for SSI, the following tools are available as long as the child support has been ordered (see POMS SI1120.200(G)(1)(d)):
  - Utilize an SNT, as long as the parent or grandparent establishing the trust "seeds" it first by using a nominal amount of his or her own money as the first asset.
  - Deposit the income to the designated beneficiary of an ABLE account.

SPECIAL NEEDS AND CHILD SUPPORT

Child Support and Public Benefits Issues for Divorcing Spouses With Special Needs Child(ren), continued: Ongoing child support for disabled child (Va. Code Ann. §20-124.2(C) (1950)).

- The court may order that support be paid for any child of the parties. Upon request of either party, the court may order that such support payments be made to a special needs trust or an ABLE savings trust account as defined in §23.1-700.

  The court shall also order that support will continue to be paid for any child over the age of 18 who is (i) a full-time high school student, (ii) not self-supporting, and (iii) living in the home of the party seeking or receiving child support until such child reaches the age of 19 or graduates from high school, whichever first occurs. The court may also order that support be paid or continue to be paid for any child over the age of 18 who is (a) severely and permanently mentally or physically disabled, and such disability existed prior to the child reaching the age of 18 or the age of 19 if the child met the requirements of clauses (i), (ii), and (iii); (b) unable to live independently and support himself; and (c) residing in the home of the parent seeking or receiving child support. In addition, the court may confirm a stipulation or agreement of the parties which extends a support obligation beyond when it would otherwise terminate as provided by law. The court shall have no authority to decree support of children payable by the estate of a deceased party. The court may make such further decree as it shall deem expedient concerning support of the minor children, including an order that either party or both parties provide health care coverage or cash medical support, or both.

SPECIAL NEEDS AND CHILD SUPPORT

Ongoing child support for disabled child

- *Gaissert v. Gaissert*, 2016 Va. App. LEXIS 224 (2016)
- *Rinaldi v. Dumsick*, 32 Va. App. 330, 528 S.E.2d 134 (2000)

SPOUSAL SUPPORT

- Change in health circumstances may be a basis to modify spousal support for both the payor and recipient of spousal support
- What if support is non-modifiable?
- Payment of Spousal Support to a trust

QUESTIONS?

33RD ANNUAL ADVANCED ELDER LAW UPDATE SEMINAR 2024

TAX CONSIDERATIONS FOR ELDER LAW ATTORNEYS

Presented by:
Melinda Merk, JD, LLM, CFP®, AEP®
Fairfax, VA
September 12, 2024

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McCandlish Lillard

AGENDA

- Income taxation of trusts (including grantor trusts)
- Gift/estate/generation skipping transfer (GST) tax overview
- SLATs and GST planning for high net worth clients
- Avoiding potential tax and other pitfalls when drafting joint revocable trusts (JRTs)
- RMDs under the SECURE Act/Final Regulations and naming trusts as a beneficiary of retirement accounts
- Miscellaneous trust funding/tax issues

INCOME TAXATION OF TRUSTS – GRANTOR TRUSTS

- **Revocable Trusts** are generally grantor trusts during the grantor's lifetime because the grantor retains the power power to revoke, terminate, alter, amend, or appoint to revest title to the trust assets in the grantor [IRC §676(a)]
  - No separate fiduciary income tax return or tax ID is required for revocable trust during grantor's lifetime
  - Trust can use grantor's SSN and all items of income and deductions for the trust can be reported on the grantor's personal income tax return
- **Inter Vivos Irrevocable Trust** can/should be designed as "intentionally defective" grantor trust ("IDGT") so the trust is disregarded and taxable to the grantor as the "owner" for Federal income tax purposes during grantor's lifetime, while avoiding inclusion of trust assets in the grantor's taxable estate [See IRC §§671-677]
- Types of Irrevocable Trusts that are typically/can be designed as IDGT:
  - Life Insurance Trust (ILIT)
  - Spousal Lifetime Access Trust (SLAT)
  - Dynasty Trust
  - Education/Minor's Trust
  - Grantor Retained Annuity Trust (GRAT)
  - Qualified Personal Residence Trust (QPRT)
  - 3rd party Special Needs Trust
  - Medicaid Asset Protection Trust

GRANTOR TRUST STATUS FOR IRREVOCABLE TRUSTS

- Benefits of grantor trust status for irrevocable trust during grantor's lifetime
  - Income taxes paid by grantor on behalf of IDGT are not considered to be a taxable gift to the trust or the beneficiaries [Rev. Rul. 2004-64]
  - Income taxes paid by grantor on behalf of IDGT further reduce the grantor's taxable estate
  - Allows trust assets to grow "income tax-free" outside of grantor's estate
  - Allows trust to qualify as S Corp shareholder
- Grantor trust status generally ceases at the grantor's death – trust then treated as a separate taxpayer and files fiduciary income tax return (IRS Form 1041)
- Rev. Rul. 2023-2 clarifies that no step-up in basis is available for IDGT at grantor's death if the trust assets are not includible in grantor's taxable estate under IRC §1014(a) – NO SURPRISE to most tax practitioners

COMMON/"SAFE" GRANTOR TRUST POWERS FOR IDGT THAT AVOID ESTATE TAX INCLUSION

- **IRC §675(2)** – give grantor the power to borrow principal or income from the trust without having to provide adequate security for the loan
  - Adequate interest should still be required to avoid unintended gift tax consequences under the below-market interest rate rules [See IRC §1274(d) and §7872]

- **IRC §675(4)(c)** – give grantor a "swap power" to "reacquire the trust corpus by substituting other property of an equivalent value" exercisable in a nonfiduciary capacity [See Rev. Rul. 2008-22]
  - Swap power can also be beneficial to swap low basis trust assets with cash or other high basis/easy-to-value assets owned by the grantor, in order to obtain stepped-up basis at grantor's death under IRC §1014(a)
  - Exercise of swap power is not a taxable event to grantor or the trust for income tax purposes [Rev. Rul. 85-13]
  - Caution: Swap power should not be permitted with regard to closely-held voting stock in a "controlled corporation" transferred to the trust, due to risk that the IRS could argue this is a retained right to vote the shares that causes inclusion in grantor's estate under IRC §2036(b)

- **IRC §674(a)** – give independent trustee power to add one or more charitable beneficiaries

- **IRC §677(a)(3)** – express power to apply trust income for payment of premiums on insurance on the life of the grantor or the grantor's spouse (which generally makes most ILITs grantor trusts)
  - Avoids "transfer for value" rule under IRC §101(a)(2) if life insurance policy is transferred or sold for adequate consideration from "old ILIT" to "new ILIT" so long as both trusts are grantor trusts [Rev. Rul. 2007-13]

OTHER DRAFTING TIPS FOR IDGT

- Discretionary (vs. mandatory) reimbursement clause can give trustee discretion to reimburse grantor for taxes paid on behalf of the trust
  - Generally, will not cause inclusion of trust assets in grantor's estate so long as there is no express or implied understanding between the grantor and trustee [Rev. Rul. 2004-64]
  - Under Rev. Rul. 2004-64, the terms of the trust required an independent trustee, i.e., someone not "related or subordinate" to grantor under IRC §672(c)
  - Applicable state law should be consulted to ensure that trustee's discretionary reimbursement power does not expose trust assets to grantor's creditors
    - See VA Code §64.2-747(A)(2) which protects trust assets from creditors of grantor for this purpose
  - IRS CCA Memo 202352018 - modification of existing IDGT to include discretionary reimbursement power results in taxable gift by the trust beneficiaries to the grantor
- Grantor trust status can be "toggled off" during grantor's lifetime if paying taxes on behalf of the trust becomes too burdensome for the grantor by releasing grantor trust powers

INCOME TAXATION OF TRUSTS – NON-GRANTOR TRUST (NGT)

- NGTs are separate taxpayers for Federal and state income tax purposes
- Generally, NGT must use calendar tax year and make estimated tax payments (absent timely Section 645 election for QRT as discussed below)
- Qualified revocable trust (QRT) that becomes NGT at grantor's death can make Section 645 election to be treated/taxed as part of grantor's estate for income tax purposes
  - QRT must still obtain its own EIN at grantor's death
  - Election is available even if no executor is appointed and there is no probate estate
  - Allows QRT to file fiduciary income tax return based on fiscal year
  - Avoids estimated tax payments for QRT for up to 2 years following the grantor's death
  - Allows QRT to qualify as S Corp shareholder without making QSST or an ESBT election – continues to qualify as S Corp shareholder for another 2 years after Section 645 election expires [IRC §1361(c)(2)(A)(iii)]
  - Section 645 election expires 2 years after the grantor's death if Form 706 is not required
  - If Form 706 is required because grantor's gross estate exceeds filing threshold, Section 645 election expires 6 months after the date of the final determination of the estate tax liability or 2 years after the date of the decedent's death (whichever is later) [Treas. Regs. § 1.645-1(f)]
- NGTs (and estates) are taxed at highest marginal ordinary income tax rate (currently 37%) at a much lower AGI threshold than individuals ($15,200 AGI for 2024 vs. $609,350 AGI for single individual and $731,200 AGI for married filing jointly)
- Net investment income tax (3.8%) also applies to NGTs (and estates) once AGI reaches highest ordinary income tax bracket, to the extent that the income is not distributed to the beneficiaries

INCOME TAXATION OF TRUSTS – NON-GRANTOR TRUST (NGT)

- NGT receives distribution deduction to the extent that "trust income" is distributed [IRC §661] – beneficiary receives K-1 to report share of trust income on their personal income tax return
- Capital gains are generally excluded from "distributable net income" (DNI) and taxable to trust, although gains can be passed through to the beneficiaries under certain exceptions [Treas. Regs. §1.643(a)-3(b)]
- 65-day rule allows trustee to treat distributions of trust income made within first 65 days of tax year as having been made in the preceding tax year if timely election is made [IRC §663(b)]
  - Generally, 65-day period ends on March 6 for calendar tax year (March 5 for leap years)
  - Gives trustee time to receive 1099s and other tax information to confirm total trust income for prior tax year
  - Estates are also eligible for 65-day rule
- Suspension of miscellaneous itemized deductions for individuals under the 2017 Tax Act does not apply to NGTs for administration expenses that would not have been incurred if the property were not held in trust [IRC §67(e)] - e.g., legal fees, accounting fees, etc.
- Charitable income tax deduction for NGT is generally limited under IRC §642(c)
  - Must be paid from "gross income" pursuant to the terms of the trust document – interpreted to mean gross taxable income (not DNI), including capital gains and income in respect of a decedent (IRD) [Treas. Regs. § 1.642(c)-3]
  - For pecuniary bequests to charity from NGT to be deductible, the trust document should expressly require that they be paid from gross income/IRD [See CCA 200644020]
  - If payment to charity qualifies for charitable contribution deduction under IRC §642(c), the trustee can elect to treat it as having been made in the preceding tax year so long as it is made by December 31 of the current tax year if timely election is made [Treas. Regs. §1.642(c)-1(b)]
  - Charitable contribution deduction for NGT is not capped by AGI limits that apply to individual taxpayers; however, no carry-over of excess charitable contributions is permitted for NGT
- IRC §121 capital gains exclusion for sale of principal residence by NGT is <u>not</u> available

GIFT/ESTATE/GENERATION SKIPPING TRANSFER (GST) TAX

- 2017 Tax Act doubled Federal estate/gift/GST exemption for US citizens and "domiciliaries" from $5MM to $10MM, indexed annually for inflation (currently, $13.61MM for 2024)
  - Doubling of exemption will automatically sunset starting in 2026
  - "Anti-claw back" regulations provide that any excess exemption used during lifetime will not be counted against the taxpayer at their death after 2025
  - 40% transfer tax rate applies to the extent total transfers during lifetime and/or at death exceed exemption amount
  - Unlimited estate and gift tax deductions for qualified transfers to U.S. citizen spouse or charity
- "Use it or lose it" time window for higher net worth clients who have already used pre-2017 Tax Act exemption ($5.49MM in 2017) to utilize excess exemption via lifetime gifts
- Portability election allows deceased spouse's unused estate and gift exemption ("DSUE") to be transferred to surviving spouse, provided surviving spouse is a US citizen
  - Timely election must be made on IRS Form 706 for deceased spouse, even if deceased spouse's gross estate does not exceed filing threshold (due 9 months from date of death, with automatic 6 month extension if needed)
  - Late portability election can be made on Form 706 filed on or before the 5th anniversary of the deceased spouse's date of death pursuant to Rev. Proc. 2022-32
  - Portability election is NOT available for GST exemption
- Marital deduction is limited for transfers to non-US citizen spouses
  - Non-taxable gifts to non-US citizen spouse limited to $175K per year (indexed annually for inflation)
  - Estate tax marital deduction is generally only available for transfers to Qualified Domestic Trust ("QDOT")
- No separate state estate or gift tax in Virginia
  - Maryland has state estate tax with $5MM exemption and top estate tax rate of 16%, with portability - plus additional 10% inheritance tax for transfers to collateral heirs (other than siblings) and unrelated beneficiaries
  - DC has state estate tax with $4,710,800 exemption and top estate tax rate of 16%, without portability

GIFT AND GST EXCLUSIONS FOR LIFETIME GIFTS

- Current annual gift tax exclusion for gifts of a "present interest" is $18K/per donee
- Outright annual exclusion gifts generally also qualify for GST exclusion – do not need to be reported on gift tax return
- Unlimited gift and GST exclusion is available for direct payments of tuition and medical expenses by donor on behalf of donee
- *Crummey* withdrawal power gifts to irrevocable trust generally qualify for the annual gift exclusion but do NOT qualify for GST exclusion (unless §2642(c) Trust)
  - Affirmative election in or out of the automatic GST allocation rules should be made on timely filed gift tax return for the year of gift
- Annual exclusion gifts to §2642(c) Trust for skip person (i.e., grandchild) can also qualify for GST exclusion provided:
  - Skip person (i.e., grandchild) is the sole current beneficiary of the trust
  - Trust assets are includible in the skip person's taxable estate (via general power of appointment)
- Annual exclusion gifts to 529 Plan account can be "front-loaded" by making election to treat lump sum gift in year 1 as being made ratably over 5-year period
  - Portion of the gift will be brought back into donor's estate if they die during the 5-year period

INCOME TAX CONSIDERATIONS FOR LIFETIME GIFTING

- Be mindful that donee generally takes carry-over basis in gifted asset for income tax purposes
- Consider updating standard fiduciary powers in revocable and irrevocable trusts to give independent trustee the power to grant testamentary general power of appointment to a beneficiary to achieve stepped-up basis in low basis trust assets at beneficiary's death, particularly for a beneficiary who will not otherwise have a taxable estate
  - Testamentary power to appoint to ***bona fide creditors*** of beneficiary's estate is sufficient to qualify as general power of appointment that would cause inclusion in the beneficiary's estate under IRC §2041and achieve stepped-up basis under IRC §1014(a)
- Consider "upstream" gifting (i.e., to donor's parent with excess estate/gift/GST exemption) to obtain stepped-up basis in highly appreciated asset, subject to one-year rule under IRC §1014(e)
  - Prohibits stepped-up basis if appreciated property is acquired by the donee within one year of donee's death and such property is acquired from the donee-decedent by (or passes from the donee-decedent to) the donor or the donor's spouse
  - Note: Legislative history of §1014(e) includes the words "directly or indirectly" but this wording is not included in the actual statute or IRS Regulations
    - But see PLR 9026036, PLR 200101021, and PLR 200210051which add "indirectly" to how §1014(e) should be applied where appreciated property passes in trust for the benefit of the donor

SPOUSAL LIFETIME ACCESS TRUSTS (SLATS)

- Irrevocable inter vivos trust/lifetime gifting receptacle to utilize and leverage estate/gift/GST exemption and shift future appreciation out of grantor's estate
- Provides grantor with indirect access to the gifted funds by naming grantor's spouse as a discretionary beneficiary (typically along with descendants)
  - Grantor's spouse can also be trustee without trust assets being includible in spouse's estate, so long as power to make distributions to themself as trustee is limited to ascertainable HEMS standard (prevents spouse from having a general power of appointment)
  - Consider using "floating spouse" provision to mitigate risk of divorce
  - Consider granting an independent non-adverse party (other than the grantor or a beneficiary) a lifetime special power of appointment ("SPAT"), exercisable in a nonfiduciary capacity, to add the grantor as a beneficiary as part of a class of beneficiaries (i.e., descendants of grantor's grandparents) = "SPLAT"
    - See O'Connor, Gans & Blattmachr, "SPATs: A Flexible Asset Protection Alternative to DAPTs," 46 Estate Planning 3 (Feb 2019).
- Generally, gift-splitting election is <u>not</u> available for gifts to SLAT due to spouse being a discretionary beneficiary of the trust
- For most married couples, generally better for one spouse to make gift to SLAT to fully utilize excess exemption amount (vs. both spouses gifting a lesser amount to reciprocal SLATs)
- Be careful to avoid reciprocal trust doctrine if each spouse is creating a SLAT
- Can be designed as grantor trust for income tax purposes during grantor's lifetime
- Can be designed as ongoing GST Exempt "Dynasty" Trust for descendants (see next slide)

GST PLANNING FOR HIGH NET WORTH CLIENTS

- Estate plans that leave inheritance outright to next generation (children) and/or give next generation a general power of appointment over inherited assets held in trust do not utilize parent's GST exemption
  - Assets will generally be includible and subject to estate taxation in the child's estate and parent's GST exemption will be wasted/unused
- GST trust planning should be considered for higher net worth clients (generally $10MM and above)
- Assets gifted or bequeathed to a "GST Exempt" Trust can be for the benefit of next generation (children) and future descendants
  - Next generation does not need to "skipped" or excluded as a beneficiary of GST Exempt Trust (which is a common misconception)
  - Child can generally be trustee of GST Exempt Trust without assets being includible in child's estate, so long as child's power to make distributions to themself as trustee is limited to ascertainable HEMS standard
  - Additional asset protection can also be achieved by leaving inheritance in trust
  - Trust assets can then pass on to grandchildren and future descendants, free of any future estate/gift/GST tax

AVOIDING POTENTIAL TAX AND OTHER PITFALLS WHEN DRAFTING JOINT REVOCABLE TRUSTS (JRTS)

- JRTs have become more prevalent given the higher Federal estate tax exemption and availability of the portability election for estate and gift tax purposes (portability election not available for GST tax exemption)
- Beware of poorly designed JRTs for non-community property that attempt to maintain separate shares for separate vs. joint property
  - Typically requires tracing of spousal contributions at the first spouse's death in order to determine what portion of the JRT is includible in the deceased spouse's estate
  - Can result in loss of stepped-up basis for income tax purposes upon first spouse's death
- Properly designed JRT mimics spousal joint ownership with each spouse deemed to own an undivided one-half of the trust assets as tenants in common
  - Each spouse should retain unilateral right to revoke their one-half share of the trust
  - Tenancy by entirety character of TBE property contributed is generally retained [VA Code § 55.1-136(C)]
  - Deceased spouse's share of JRT becomes irrevocable upon his or her death, and passes to surviving spouse's share (with ability to disclaim into Family Trust) or retained in Marital Trust
  - Surviving spouse's share of JRT remains revocable and amendable during his or her lifetime
  - Consider using side marital agreement to state that any equalizing transfers are for estate planning purposes only and not intended to be converted to marital property (in case of divorce)
- Generally, JRTS are not recommended for couples with significant amounts of separate property they wish to keep separate, or for couples with children from a prior marriage
  - Consider doing separate RLT for spouses' separate property and JRT for joint/marital property

RMD'S UNDER SECURE ACT AND FINAL REGULATIONS

- SECURE Act generally applies to with regard to RMDs payable from inherited IRAs and qualified plans after 12/31/2019 (including Roth IRAs)
- Replaces life expectancy payout method with 10-year rule for **non-eligible designated beneficiaries** [IRC §401(a)(9)(H)]
  - 10-year rule applies regardless of whether participant dies before or after required beginning date (RBD), unless there is no "designated beneficiary" (see below)
  - Final Regs issued in June 2024 require annual distributions during 10-year period from traditional IRA when owner dies on or after his/her required beginning date (RBD)
  - IRS has provided relief from excess accumulation penalty for any beneficiary that failed to take an annual RMD in 2021, 2022, and/or 2023, and/or fails to in 2024
- Certain **eligible designated beneficiaries** (EDBs) – such as surviving spouse or disabled beneficiary – can still take RMDs over their life expectancy [IRC §401(a)(9)(E)(ii)]
- Old rules still apply re: definition of "designated beneficiary" and whether trust qualifies as a "see-through" trust/designated beneficiary
- Old rules still apply if there is no "designated beneficiary" (e.g., payable to estate, charity, or to trust that does not qualify as a see-through trust)
  - 5-year rule if participant dies before RBD, or
  - Life expectancy of the participant if he/she dies after RBD ("ghost" life expectancy)

MISCELLANEOUS TRUST FUNDING/TAX ISSUES

- Avoid naming Revocable Trust as beneficiary of IRA or retirement account
  - Instead, specifically name subtrust (e.g., Marital Trust, Trusts for Descendants, etc.) in the beneficiary designation
  - Always best to directly name charity as beneficiary of IRA rather than naming revocable trust as beneficiary that includes pecuniary charitable bequests, due to limitations on charitable deduction for estates and trusts under IRC §642(c) as discussed on Slide 8
- Do not assign ownership of single member LLC interest to JRT, as this will disqualify the LLC as a disregarded entity for income tax purposes (see https://www.irs.gov/businesses/small-businesses-self-employed/single-member-limited-liability-companies)
  - Instead, prepare TOD designation for LLC interest and, ideally, prepare operating agreement for LLC with designation of successor manager
- Avoid traditional A/B trust planning for married couples that automatically directs deceased spouse's unused exemption to Credit Shelter Trust (CST) at first spouse's death
  - Generally, no stepped-up basis will be available for CST at surviving spouse's death
  - Funding of CST is not necessary for most clients due to portability election
  - Consider disclaimer trust planning or "one-lung" QTIP Marital Trust to maximize flexibility and post-mortem estate tax planning after first spouse's death, due to uncertainty and unforeseen estate tax law changes

QUESTIONS?

THANK YOU!

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Real property – Protecting the House when Qualifying for Medicaid

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In middleclass America, it's common for a person's home to be his most valuable asset. Losing that home to the cost of long term care can be heartbreaking. But when attempting to "save" the house, Elder Law attorneys must proceed with care: tampering with the title to real property may have unintended consequences impacting the client's estate and tax plans. In this section, we will review a variety of strategies to protect the house while maximizing eligibility for Medicaid, along with a discussion of how to mitigate possible negative impacts to other areas of planning. This is not a comprehensive list of all possible Medicaid strategies; instead, this outline is intended as a brief introduction to some of the most common house-protecting strategies.

Throughout this outline, the person who needs Long Term Care (LTC) will be referred to as "the client" or "the applicant." That person's spouse will be referred to as the "Community Spouse."

EARLY PLANNING

Early planners may be concerned about the cost of Long Term Care (LTC) in the future, even though they don't need it now. Medicaid only considers (and potentially penalizes) transfers that happened within the five years previous to the time of application.[1] Therefore, if we think the client can make it five years before applying for Medicaid, we can try some "early planning" strategies to protect the real property.

A. TRANSFER TO A MEDICAID PROTECTIVE TRUST. Certain irrevocable trusts can shelter assets from Medicaid.[2] There are several kinds of trusts with various benefits and drawbacks; a discussion of these intricacies is beyond the scope of this outline.

1. Benefits of a Medicaid Protective Trust:
    a. If done properly, assets held in the irrevocable trust are NOT countable for Medicaid.
    b. Five years after the transfer to the trust, the transfer won't be subject to any gifting penalty.
    c. Depending on the terms of the trust, the client may still have a great deal of control over the trust assets.
    d. If we sell the house in the future, all of the proceeds go to the trust, where they remain protected and (usually) available in some way for the benefit of the client.
    e. The trust ensures that the client's property passes to the proper beneficiaries when the client dies, along with any contingencies or protections for the beneficiaries.
2. Drawbacks of a Medicaid Protective Trust:
    a. The client no longer has total control of the asset (this is true of just about any Medicaid planning technique).
    b. It takes time, money, and effort to get the trust set up.
    c. Some clients may not like the complexity of a trust, or they may have a hard time understanding it.
    d. Depending on the type of trust, the trustee may need to file a separate income tax return for the trust.
    e. The client may lose out on special tax breaks or other benefits connected to his ownership in the house (for example, if his property taxes are exempt due to his status as a disabled veteran).
    f. The transfer of assets to the trust is an "uncompensated transfer" which is subject to penalty for five years after the transfer is made. So if the client needs LTC sooner than five years, the transfer to the trust will result in the assessment of a penalty period.

[1] M1450.600 At the time of application, an applicant must disclose any uncompensated transfers within the last five years. Some uncompensated transfers are not penalized (such as transfers to a spouse, to a blind/disabled child, or to a minor child). The value of all other transfers is totaled and divided by 7,023 (or by 9,268 for certain jurisdictions in Northern Virginia). The result is the number of months from which the person is disqualified from receiving Medicaid.

[2] M1120.200 Medicaid Manual Reference providing a discussion of whether assets in a trust are countable Medicaid assets.

g. If the client wants to scrap the trust and change strategies (which may be needed in the situation above), it is impossible for the trust to return the money to the client and "cure" the gift.[3]
h. Depending on the type of irrevocable trust, the beneficiary may lose out on the step-up in basis when the client dies.[4]

B. THE LIFE ESTATE DEED. The client can gift the house to someone (usually the kids) while retaining a life estate in the property. In this situation, the gift to the kids is a completed gift that is irrevocable (though the kids may choose to return the gift if they want). The client owns the "life estate" and is called the "life tenant." The kids own the "remainder interest" and are called the "remaindermen."

1. Benefits of the Life Estate Deed
   a. A life estate is NOT a countable asset for Medicaid.[5]
   b. Five years after the transfer of the house, the transfer won't be subject to any gifting penalty.
   c. The client retains the exclusive right to occupy the house during his lifetime. This includes the right to any rental proceeds. The client's life estate does NOT terminate the right to use the house as his primary residence.
   d. The client retains any tax breaks or other benefits in connection to his home ownership (for example, the disabled veteran will still get his property taxes waived).
   e. Compared to the trust strategy, a life estate deed is inexpensive, quick, and simple. I have many clients who are willing to do a life estate deed, but would never agree to the complexity and expense of a trust. So you really get a lot of "bang for your buck" with this one.
   f. The life estate deed has no impact on the client's taxes (other than reporting the initial gift).
   g. The basis step-up is preserved.
   h. As long as the remaindermen are willing to gift the house back to the client, we always have the option to "cure" the gift and choose a different strategy at any time. This is extremely helpful if the client needs LTC before the five year penalty period has passed. We simply "reverse" the deed and pick one of the strategies in the "crisis planning" section.

[3] Medicaid allows for the "cure" of an uncompensated transfer. In other words, if the recipient of an uncompensated transfer simply returns the transferred assets, the gift is "cured", and no penalty is assessed. Most irrevocable trusts do not allow for transfers of assets directly to the grantors, so it is impossible to cure a gift to a irrevocable trust.

[4] 26 U.S. Code § 1014. For tax purposes, the "basis" is the base number that you use to calculate the gain of an appreciated asset. That gain may be subject to capital gain taxes. For example, if I buy a house for $200k, and I sell it for $250k, my basis is the $200k purchase price. I will owe capital gain taxes on the difference between my basis and the sale price, which in this case would be $50k (this is a *grossly* simplified example). If I gift the house to someone during my lifetime, the house's basis transfers along with it (meaning that the recipient now has the same $200k basis that I did). However, if I keep the house until my death, my heir's new basis is whatever my house was worth when I died. Let's say my house is worth $260k when I die, and my heir sells it two years later for $270k. My heir only pays capital gain taxes on $10k because he got a "step up in basis" to $260k. No one will ever have to pay taxes on the $60k of appreciation from the time I bought the house until my death.

[5] M1110.515. A life estate is not a countable asset.

i. Ownership of the house has been transferred to the client's intended beneficiaries. If desired, the client can even retain the power to change the remaindermen, so long as the remaindermen are selected from a specific, predetermined group of people (usually the client's descendants). This allows the client to retain some flexibility with his estate plan.

2. Drawbacks of the Life Estate Deed
   a. The client no longer has total control of the house (this is true of just about any Medicaid planning technique).
   b. The transfer of the house is an "uncompensated transfer" which is subject to penalty for five years after the transfer is made. So if the client needs LTC sooner than five years, the execution of the life estate deed will result in the assessment of a penalty period.
   c. The house may be subject to the liabilities and creditors of the remaindermen (though I have never seen any creditor come after the house while the tenant is still alive).
   d. If we sell the house in the future, the client receives a portion of the proceeds. These funds are NOT protected from Medicaid.
   e. Since the remaindermen have already received their gift, they cannot benefit from the contingencies or protections that may be present in a trust.

CRISIS PLANNING

It would be great if all our clients planned for Medicaid five years in advance. However, most of them don't. Most people walk in the door when they need Medicaid NOW. Of course, the client can always sell the house and then deal with the countable proceeds using non-real property strategies. However, for the purpose of this outline, I'm assuming that the client wants to keep the house.

A. BASIC PRINCIPLES. Before we get into the strategies, here are some basic principles to keep in mind:
    1. The house is not countable if the applicant is living in it.[6] Many clients remain in their homes and receive LTC Community-based Medicaid services. In these cases, the home is exempt. However, we may need a contingency plan for when/if the client leaves the home.
    2. The house is not countable if the applicant is married.[7] However, if the spouse dies before the applicant does, the house will be countable. So we will need a contingency plan for that scenario.
    3. The house is not countable for the first six months in which the applicant lives in a nursing home (the rationale is that the person may recover and return home). Many people pass away shortly after they enter a nursing home, so in these situations, the house will never be countable.[8]

B. TRANSFER TO BLIND, DISABLED, OR MINOR CHILD: This strategy allows transfers of real property to an applicant's blind or disabled child without affecting the applicant's eligibility for Medicaid. This strategy also works for transfers to minor children, which are defined as children under age 21. When property is transferred to a blind, disabled, or minor child, the transfer does not cause a Medicaid disqualification period.[9]
    1. Benefits of transfers to a blind/disabled/minor child:
        a. Simple, easy, cheap.
    2. Drawbacks of transfers to a blind/disabled/minor child:
        a. Most LTC Medicaid applicants don't have a blind, disabled, or minor child.
        b. Giving a house to minor child is obviously a bad idea.
        c. Often, giving the house to a disabled person just passes the problem from one person to the next. If the disabled person is on Medicaid, then the house may now disqualify him or her.
        d. The child will miss out on the step-up in basis when the parent dies.
        e. The blind, disabled, or minor child may not be the person to whom the client was hoping to leave his house.
    3. But… Medicaid doesn't count the house if you have a blind, minor, or disabled child living in the home.[10] So simply having the child move into the house could fix the problem (at least temporarily).

[6] M1130.000(A) Medicaid Manual reference: the home is not counted if the applicant lives there.
[7] M1130.000(D)(3) Medicaid Manual reference: the home is exempt if the spouse is living there.
[8] M1130.000(D)(2) Medicaid Manual reference for six month exclusion rule.
[9] M1450.000(C)(1) Transfers of home property to a spouse, minor child, or blind/disabled child are not penalized.
[10] M1130.000(D)(3) Medicaid Manual reference: the home is exempt if certain individuals live there.

C. TRANSFER TO A CARETAKER CHILD: A home that is transferred to a "caretaker child"[11] does not invoke a penalty. To qualify for this exemption, the adult child must (1) have lived with the applicant for the two-year period directly preceding the client's institutionalization[12], and (2) have been providing care that has allowed the client to stay in the home, rather than going to a facility.

1. Benefits of the Caretaker Child Transfer
    a. Simple, easy, cheap.
    b. Provides the client with a way to compensate the child (at least partially) for years of dedicated care.
2. Drawbacks of the Caretaker Child Transfer
    a. The years of care must happen directly before the institutionalization. So let's say that daughter lived with mom for four years, providing the necessary care. But then mom goes to an assisted living facility. After six months at the assisted living facility, mom transfers to a nursing home. The caregiver child transfer doesn't work because the years of care did not directly precede the institutionalization (since assisted living doesn't count as institutionalization).
    b. This strategy doesn't work for stepchildren, grandchildren, or in-laws.
    c. The Caretaker Child may not be the person to whom the client was hoping to leave her house.
    d. The Caretaker Child will miss out on the step-up in basis.

D. UNSUCCESSFUL EFFORTS TO SELL: LIST REAL PROPERTY FOR TAX ASSESSED VALUE: Medicaid doesn't count the house if you are making "reasonable" but unsuccessful efforts to sell.[13] You can satisfy this requirement by simply listing the home for sale at tax-assessed value. Medicaid always assumes that the true value of the home is its tax-assessed value[14]; therefore, listing it for sale at that value is always "reasonable," regardless of the *real* value.

1. Benefits of Listing the House for tax-assessed value
    a. This strategy works great when the home isn't actually worth tax-assessed value (as is often the case when the elderly person hasn't had the physical or financially ability to properly care for the house). The house can stay listed indefinitely and the client won't lose eligibility.
    b. If the applicant is married, you can (1) transfer the real property solely into the name of the community spouse, (2) list the house for sale at TAV, (3) get the

[11] M1450.000(C)(3) Medicaid Manual reference for the Caregiver Child requirements.

[12] M1410.010(B) "Institutionalization" is established when a person receives 30 consecutive days of care in a hospital and/or nursing home, OR when a person receives in-home LTC services through Medicaid community-based services. The 30-days may be achieved with any combination of these services. For example, a person may stay in a nursing home for two weeks, and then get discharged to home where he receives in-home LTC Medicaid services for another three weeks. In this scenario, the person is "institutionalized" because he has received a combination of acceptable services for 30 consecutive days. Institutionalization is also achieved when a person has a signed hospice election in effect for 30 consecutive days.

[13] M1130.140 The Medicaid Manual provides several ways to establish "reasonable but unsuccessful efforts to sell." In this outline, I have only mentioned listing the house for sale at TAV, because that is often the easiest and least complicated method. But other methods may also be useful, so I recommend reviewing this section.

[14] M1130.000 Appendix 1. This Appendix gives the rules for determining the value of real property.

applicant spouse on Medicaid, and then (4) immediately take down the listing. This works because Medicaid does not count the assets of the community spouse after the initial application period.[15] So in this scenario, the house only needs to stay on the market for a matter of weeks, and then the community spouse can do whatever s/he wants with the house.

2. Drawbacks of Listing the house for tax-assessed value
    a. This strategy doesn't work so well if the true value is equal to or greater than the tax assessment. Then the house will actually sell, and the proceeds will be countable.
    b. If the applicant is single, the house must stay listed indefinitely. If the house isn't going to sell, this may not be an issue. It's just a little less convenient than the married example, where the house can be taken off the market right after eligibility.
    c. If the applicant is single, the house may be subject to Medicaid Recovery (see the following section)

E. A WORD ON MEDICAID RECOVERY: Medicaid has the right to pursue an applicant's estate for recovery of the costs of the services rendered. In many situations, the applicant has no assets left when he dies, so there is nothing to recover against. However, if we use any strategy that results in the applicant owning a house at the time he dies, we must consider the risk of estate recovery.
    1. The Third Party Liability/Estates (TPL) unit is the entity in charge of estate recovery in Virginia.
    2. TPL will NOT seek recovery when the applicant is survived by a spouse, a blind/disabled child, or a child under 21.
    3. When a Medicaid recipient dies, TPL sends the family a letter asking about the recipient's assets. This letter is not an official claim; it is simply a fishing exercise to help TPL determine whether or not there are sufficient assets for them to pursue. Unless someone has qualified as the personal representative of the estate, no one is under any obligation to respond to this letter. In my experience, if no one responds to the letter, TPL drops the matter and never follows up again.
    4. In my 10+ years of experience, the *only* time I have seen Medicaid/TPL pursue estate recovery was when my client qualified as the personal representative of the recipient's estate. In most situations, qualification is not necessary, so Medicaid never pursues recovery. My discussions with other elder law attorneys have confirmed that my experience is typical across the Commonwealth: though it has the right to do so, Medicaid tends *not* to pursue estate recovery unless a person qualifies on the estate.
    5. In summary, Virginia residents shouldn't be too concerned about estate recovery against the house. At this time, estate recovery simply isn't a priority for TPL/Medicaid.

[15] M1480.230 Medicaid Manual Reference explaining that the resources of the community spouse are not countable after the initial eligibility period. Once the applicant is approved, the community spouse could win the lottery and it wouldn't impact the applicant's Medicaid. So in a situation with a house, you can simply remove the applicant from the title and list the house for sale at TAV to "get through" the eligibility period. Once the eligibility period is passed, Medicaid is never going to look at the house again because it is solely the asset of the community spouse.

Special Needs Planning: It's More than Just a Trust

By: Shannon A. Laymon-Pecoraro, CELA

I. Introduction

Pursuant to the Social Security Administration, a disability is the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.[1] A child under age 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.[2]

Disability status transcends all demographic boundaries - gender, nationality, ethnicity, socioeconomic status, and educational attainment. As of 2022, a significant 13.4% of the non-institutionalized American populace was classified as disabled, according to data from the Cornell University Yang-Tan Institute.[3]

In our practice, we must recognize that crafting plans for individuals with disabilities extends far beyond the mere creation of a trust instrument. While trusts serve as vital repositories for funds, they represent only one facet of a comprehensive strategy. Our approach must be dynamic, evolving throughout the client's lifetime, and should be tailored to address the unique aspects of an individual's disability, their particular strengths and limitations, and their personal aspirations.

Our duty as elder law practitioners necessitate a holistic assessment that encompasses not only traditional legal planning elements - such as guardianships, public benefits eligibility, and trust structures - but also what we might term 'soft issues.' These include, but are not limited to, residential placement considerations, education and employment opportunities, and ongoing advocacy efforts. Our role demands that we serve not just as legal advisors, but as architects of comprehensive life plans for our clients with disabilities. This approach ensures that we fulfill our professional obligations while providing the most effective and personalized service to this significant portion of our clientele.

II. Residential Planning

In the realm of special needs planning, attorneys must be acutely aware of the profound emotional challenges involved in planning. Two events stand out as particularly traumatic in these individuals' lives: relocating from the family home and experiencing the

[1] 42 U.S.C. §1382(c)(3)(A).
[2] *Id.* at (C).
[3] Erickson, W., Lee, C., von Schrader, S. (2022). Disability Statistics from the American Community Survey (ACS). Ithaca, NY: Cornell University Yang-Tan Institute (YTI). Retrieved from Cornell University Disability Statistics website: www.disabilitystatistics.org

loss of parents. These transitions, challenging for anyone, can be especially destabilizing for those with special needs.[4]

Of critical concern is the potential for these two seismic life changes to occur in tandem. When an individual with special needs transitions to a new residential living arrangement following parental death, they endure what can be described as a "double blow." This confluence of major life upheavals can severely impact the individual's emotional well-being and ability to adapt.

To mitigate this risk, there should be proactive planning.[5] It is advisable to encourage parents to initiate and oversee their child's transition to a new living arrangement while they are still capable of providing support. This strategy offers multiple benefits:

- It allows for a gradual adjustment period, with parents available to provide comfort and guidance.
- Parents can actively participate in resolving any issues that arise during the transition.
- It provides an opportunity to establish and refine support systems under parental supervision.
- It separates the stress of relocation from the trauma of parental loss, allowing the individual to process these significant life changes sequentially rather than simultaneously.

This approach not only addresses the financial and legal aspects of special needs planning but also demonstrates a commitment to the holistic well-being of the individual with special needs. This comprehensive strategy aligns with best practices in elder law and special needs advocacy, potentially reducing trauma and fostering long-term stability for the client's loved one.

Residential planning is not a one-time decision but an ongoing process. Needs may change over time, and the chosen living arrangement should be periodically reassessed to ensure it continues to meet the individual's needs.

A. Fair Housing

[4] An interesting article published in the Harvard Review of Psychiatry related to grief and its complications for individuals with intellectual disabilities can be found here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3166634/.

[5] A study on the topic of planning for parental death for individuals with intellectual disabilities was performed in the United Kingdom. The article pertaining to the study can be found here: https://onlinelibrary.wiley.com/doi/10.1111/jar.13174.

The Fair Housing Act Amendments (FHAA) of 1988 play a crucial role in protecting the rights of individuals with disabilities in the housing market.[6] These amendments prohibit discrimination[7] based on disability in most residential units, with certain notable exceptions.[8] For instance, the FHAA does not apply to owner-occupied buildings with four or fewer dwelling units, nor does it cover the sale or rental of a single-family house if the owner possesses three or fewer such dwellings and refrains from using a broker or advertising.[9]

B. Residential Options

1. Family Home Arrangements

Family Care Arrangements often emerge as a primary consideration for many families. While the prospect of a loved one caring for an individual with disabilities can seem ideal, it's essential to approach this option with careful planning and realistic expectations. When clients express interest in this arrangement, whether it involves the disabled individual moving in with a caregiver or vice versa, several factors warrant thorough discussion. First and foremost, financial provisions must be addressed. Ensure that adequate funds are available to cover the individual's living expenses, including but not limited to food, clothing, medical care, and personal items. If the caregiver is moving into the disabled individual's home, additional considerations such as property maintenance, utilities, and potential property tax implications must be factored into the financial plan.

Perhaps equally important is the need for a frank and comprehensive discussion with the potential caregiver about their willingness and ability to assume long-term care responsibilities. Many families experience heartache when well-intentioned relatives or friends realize they are unprepared for the demands of caregiving. There should be open dialogues that address the full scope of care needs, potential challenges, and the impact on the caregiver's personal and professional life. These conversations can help prevent future conflicts and ensure that all parties enter into the arrangement with clear expectations.

To protect all parties involved, consider drafting formal agreements that outline living arrangements, financial compensation, and potential property transfers. For instance, if parents intend to leave their home to the caregiver, this should be clearly documented in estate planning documents. A better course of action may be to leave the home to the individual with a disability and at their death have the property pass to the

[6] 42 U.S.C. §3601 *et seq.*
[7] In rental housing, discrimination is defined as the make reasonable accommodations in rules, policies, practices, or services, which would be necessary to afford a person with a disability an equal opportunity to use and enjoy the dwelling.86 A reasonable accommodation is a modification in the way the landlord normally does things that would allow the person with a disability to have an equal opportunity to use and enjoy his or her residence. *See* 42 U.S.C. §3604.
[8] *Id.*
[9] *Id.*

caregiver. Additionally, advise clients on the importance of maintaining flexibility in these agreements, as care needs and family dynamics may evolve over time.

While family care arrangements can provide a loving and familiar environment, it's crucial to acknowledge their potential limitations. Family caregivers, despite their best intentions, often lack professional training in specialized care and may struggle to provide comprehensive employment, educational, and social opportunities for the individual with disabilities. To address these gaps, encourage families to explore supplemental services and programs. Adult day services, vocational training, and community integration programs can offer structured activities, socialization opportunities, and skill development. These resources can typically be accessed through local governmental agencies.

For families opting to maintain their loved one in the family home, whether under family care or with professional support, home modifications often become a necessary consideration. As elder law attorneys, we should be prepared to discuss various aspects of home adaptation to ensure safety, accessibility, and comfort for individuals with disabilities. Accessibility improvements form the foundation of most modification plans. This may include installing ramps for wheelchair access, widening doorways to accommodate mobility devices, or even considering elevator installations for multi-story homes. The extent of these modifications will depend on the individual's specific needs and the home's existing layout.

Safety features represent another critical area of home modification. Fall prevention measures, such as grab bars in bathrooms and non-slip flooring, can significantly reduce the risk of injury. Emergency response systems should be considered to provide quick access to help when needed. For individuals with more severe physical limitations, specialized equipment like ceiling track hoists may be necessary to facilitate safe transfers and movement within the home.

For clients caring for individuals with sensory sensitivities, particularly those on the autism spectrum, sensory-friendly design modifications can dramatically improve quality of life. This might involve adjusting lighting options to reduce glare or harshness, incorporating sound-dampening materials to minimize auditory distress, and choosing calming color schemes that promote a sense of well-being. As legal professionals, while we may not be experts in design, we should be prepared to connect our clients with occupational therapists or specialized designers who can provide tailored recommendations.

Funding these modifications can be a significant concern for many families. Funding may be found through grants offered by non-profit organizations, tax credits for accessibility improvements, or looking into loan programs specifically designed for home modifications related to disability needs. Additionally, for eligible veterans, the VA offers grants for home modifications that can be a valuable resource.

2. Group Homes

Group homes represent another viable option for many individuals with disabilities, offering a balance between independence and support. These residential facilities, typically located in community settings, can vary widely in terms of the level of care provided and the specific populations they serve.

There are several types of group homes, each catering to different needs and levels of independence. Developmental Disability (DD) homes are designed for individuals with intellectual or developmental disabilities and often focus on life skills training and community integration. Mental Health group homes cater to individuals with psychiatric disabilities, providing a supportive environment with access to therapeutic services. Specialized homes exist for specific conditions, such as autism, where the physical environment and daily routines are tailored to meet the unique needs of residents.

The level of care provided in group homes can vary significantly. Some facilities offer 24/7 live-in management, with staff responsible for meal preparation, transportation, skills training, and addressing social and behavioral challenges. Others may employ a rotating staff model to provide round-the-clock support. For individuals with less severe disabilities, the level of on-site support may be reduced, with staff members visiting periodically to assist with meals, medication management, or other specific needs.

One of the primary benefits of group home living is the availability of professional supervision combined with organized social, employment, and educational assistance. This structured environment can be particularly beneficial for individuals who thrive on routine and benefit from consistent support. Moreover, the peer living arrangement inherent in group homes offers opportunities for socialization and the development of interpersonal skills, which can be invaluable for many individuals with disabilities.

When advising clients on group home options, it's essential to provide guidance on evaluating the quality and appropriateness of different facilities. Key factors to consider include staff-to-resident ratios, which can significantly impact the level of individualized attention residents receive. The qualifications of staff members and turnover rates should also be scrutinized, as consistency and expertise in caregiving are crucial for residents' well-being. Encourage clients to inquire about the programming offered, including opportunities for community integration, skill development, and recreational activities. The physical environment of the home, including its location, accessibility features, and overall condition, should align with the needs and preferences of the individual with disabilities.

3. Institutional Care

Institutional care, traditionally provided in large, self-contained facilities, has long been a part of the care continuum for individuals with severe disabilities. These facilities, which may be publicly or privately owned and operated, typically offer a comprehensive range of services including custodial supervision, evaluation, treatment, and training. The

level of care in these settings tends to be more intense, catering to individuals with complex needs that may be challenging to meet in less structured environments.

However, it's crucial for elder law attorneys to be aware of the evolving landscape of institutional care. There is a significant trend, driven by both policy initiatives and changing societal attitudes, to transition residents from large institutions into less restrictive, more community-integrated settings. This shift is rooted in the recognition of the importance of autonomy, dignity, and quality of life for individuals with disabilities, as well as in compliance with legal mandates such as the Americans with Disabilities Act[10] and the Supreme Court's Olmstead[11] decision.

Despite this trend, institutional care continues to play a role in the care spectrum, particularly for individuals with very severe disabilities who require round-the-clock supervision and medical attention. When advising clients considering institutional care, it's important to discuss the potential benefits, such as comprehensive care and constant supervision, as well as the potential drawbacks, including limited autonomy and community integration.

a. Assisted Living Facilities

Assisted living facilities represent a vital middle ground between fully independent living and more intensive institutional care. These facilities are designed to provide a balance of independence and support, catering to individuals who need some assistance with daily living activities but do not require the level of care provided in a nursing home or other institutional setting.

The assisted living landscape is diverse, with facilities offering varying levels of care and specialized services. There are nuances of different types of assisted living options:

- Traditional Assisted Living: These facilities typically provide assistance with activities of daily living (ADLs), meal preparation, medication management, and some level of health monitoring. They often offer a more home-like environment than institutional settings, with private or semi-private apartments and common areas for socialization.

- Memory Care Units: Specialized assisted living facilities or units within larger communities designed specifically for individuals with Alzheimer's disease or other forms of dementia. These units typically feature enhanced security measures to prevent wandering, specialized programming to support cognitive function, and staff trained in dementia care.

[10] 42 U.S.C. § 12101 *et seq.*

[11] In this case the Supreme Court ruled that isolating people with disabilities through institutionalization is a form of disability discrimination that violates Title II of the Americans with Disabilities Act. *Olmstead v. L.C.,* 527 U.S. 581 (1999).

- Facilities with On-Site Medical Care: Some assisted living facilities offer more extensive medical services, bridging the gap between traditional assisted living and skilled nursing care. These may include on-site physicians, more intensive nursing care, and the ability to handle more complex medical needs.

- Behavioral Health-Focused Assisted Living: These specialized facilities cater to individuals with mental health conditions, offering a supportive environment with access to therapeutic services and staff trained in managing behavioral health issues.

It is crucial to evaluate the levels of care and services provided. This assessment should include the levels of care offered, availability of therapy services, medication management capabilities for complex medication regimens, and social and recreational programming.

b. Skilled Nursing Facilities

Skilled nursing care remains a crucial component of the long-term care continuum, particularly for individuals with severe disabilities or complex medical needs. Skilled nursing facilities (SNF), also referred to as nursing homes, provide 24-hour supervised care, offering a level of medical attention and specialized services that is intended to surpass what's available in other residential settings. These facilities are designed to meet the needs of individuals who require constant nursing care and have significant difficulty coping with the activities of daily living (ADLs).

Key features of skilled nursing care include:

- Medical Supervision: Licensed healthcare professionals, including registered nurses (RNs) and licensed practical nurses (LPNs), are on staff 24/7 to provide and oversee medical care.

- Rehabilitative Services: Many SNFs offer intensive physical, occupational, and speech therapy services, often as part of post-acute care following a hospital stay.
- Complex Medical Care: SNFs are equipped to handle complex medical needs such as wound care, intravenous (IV) therapy, and management of chronic conditions.

- Specialized Units: Many nursing homes have dedicated units for specific populations, such as those with advanced dementia or those requiring ventilator care.

- Personal Care Assistance: Certified nursing assistants (CNAs) provide hands-on help with ADLs such as bathing, dressing, and eating.

- Nutritional Support: Dietary services, including specialized diets and feeding assistance, are standard in these facilities.

Federal and state laws provide extensive protections for nursing home residents; however, such protections are often violated. Additionally, the quality of care may not be what is envisioned. Family should participate in care plan meetings, where the facility staff, resident, and family members discuss goals and strategies for care.

4. Supported Independent Living

For individuals with milder disabilities who possess good living and social skills, supported independent living can offer an optimal balance of autonomy and assistance. This model allows individuals to live by themselves or with roommates while receiving limited supervision and targeted support as needed.

Key components of supported independent living include:

- In-Home Support Services: These can range from personal care assistants who help with ADLs to home health aides who provide more medically-oriented care. Visiting nurses may also be part of the support team, providing periodic health assessments and medical interventions as needed.

- Community Integration Programs: These are crucial for promoting independence and quality of life. They may include:

    1. Supported Employment Opportunities: Programs that help individuals find and maintain meaningful employment, often with on-the-job support.

    2. Day Programs and Recreational Activities: Structured activities that promote socialization, skill development, and community engagement.

    3. Transportation Assistance: Services that help individuals navigate their community independently.

- Case Management: Many individuals in supported independent living benefit from case management services to coordinate various aspects of their care and support.

- Financial Management Assistance: This can range from basic budgeting support to more comprehensive money management services, often a crucial component for maintaining independence.

C. Factors to Consider When Choosing Placement

The decision-making process of choosing appropriate residential placement for individuals with disabilities is complex and personal. There are a number of factors that influence placement decisions.

1. Level of Care Needed

The level of care required is perhaps the most critical factor in determining appropriate placement options. This consideration encompasses several key components that must be carefully evaluated to ensure the individual's needs are met comprehensively and effectively.

a. Medical Needs

When assessing medical needs, it's essential to consider both the complexity and frequency of required medical interventions. Some individuals may require round-the-clock nursing care, while others may need only periodic medical oversight. In Virginia, the level of medical care required can significantly influence placement options and funding sources.

For individuals with complex medical needs, skilled nursing facilities (SNFs) may be the most appropriate option. Virginia has numerous licensed SNFs that provide 24-hour nursing care, rehabilitation services, and specialized medical treatments. These facilities are regulated by the Virginia Department of Health and must meet stringent state and federal standards.

For those with less intensive medical needs, assisted living facilities (ALFs) or adult foster care homes may be suitable. Virginia's Department of Social Services licenses and regulates these facilities, which can provide assistance with medication management and basic health monitoring.

It's crucial to consider the stability of the individual's medical condition and the potential for changes over time. A placement that meets current needs may become inadequate if the person's condition deteriorates. Clients should consider facilities that can accommodate changing needs or have established relationships with higher levels of care for smooth transitions if necessary.

2. Daily Living Assistance

Evaluating the level of support needed for activities of daily living (ADLs) such as bathing, dressing, and eating is crucial in determining the appropriate level of care. In Virginia, the Department for Aging and Rehabilitative Services (DARS) uses a Uniform Assessment Instrument (UAI) to assess an individual's functional capacity and determine eligibility for various long-term care services.

For individuals requiring minimal assistance with ADLs, independent living arrangements with in-home support services may be sufficient. Virginia's Medicaid waiver programs, such as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver, can provide funding for personal care services in home and community-based settings.

Those needing more substantial assistance might be better served in assisted living facilities or group homes. Virginia's regulations for assisted living facilities define two levels of care: residential living care for those who need minimal assistance, and assisted living care for those requiring a higher level of care.

a. Behavioral Support

Assessing the need for specialized behavioral interventions or crisis management is particularly important for individuals with developmental disabilities, mental health conditions, or cognitive impairments. Virginia offers several specialized options for individuals requiring intensive behavioral support, including mental health treatment, substance use and addiction services, and services for intellectual and developmental disabilities. These services are provided by the state's community services boards (CSBs)[12] and the Behavioral Health Authority (BHA), which are established by local governments. You can use the Virginia Association of Community Services Boards (VACSB) directory to find a CSB near you.[13]

The Department of Behavioral Health and Developmental Services (DBHDS) licenses group homes that specialize in serving individuals with behavioral challenges.[14] These homes often have higher staff-to-resident ratios and employees trained in de-escalation techniques and positive behavioral support strategies.

When considering placement options, it's crucial to evaluate the facility's capacity to manage challenging behaviors, their staff training protocols, and their policies on the use of restraints or seclusion. Families should thoroughly investigate these aspects to ensure the safety and well-being of their loved ones.

3. Social Opportunities

The importance of social interaction and community involvement cannot be overstated when considering residential placement options. These factors significantly impact an individual's quality of life and overall well-being.

a. Peer Interaction

Consider the importance of socializing with peers who have similar challenges and interests. Group homes and larger residential facilities often provide built-in opportunities for peer interaction. Many group homes organize regular social activities and outings for residents.

[12] There are 39 CSBs in the Commonwealth offering a variety of services. More information can be found here: https://vacsb.org/community-services-boards-and-the-behavioral-authority-csbs-and-the-bha/.
[13] https://dbhds.virginia.gov/behavioral-health/mental-health-services/#:~:text=Virginia's%20community%20services%20boards%20(CSBs,for%20providers%20by%20zip%20code.
[14] https://dbhds.virginia.gov/clinical-and-quality-management/office-of-licensing/.

For individuals who thrive on peer relationships, consider placement options that have a diverse resident population and structured social programs. Some facilities in Virginia specialize in serving specific populations, such as young adults with disabilities or seniors with early-stage dementia, which can provide targeted social opportunities.

b. Community Involvement

Evaluate opportunities for integration into the broader community through work, volunteering, or recreational activities. Virginia has several initiatives to promote community integration for individuals with disabilities.

The Virginia Department for Aging and Rehabilitative Services (DARS) offers vocational rehabilitation services to help individuals with disabilities prepare for, secure, or regain employment. When considering placement options, investigate whether the facility has partnerships with local employers or day programs that facilitate community-based employment or volunteering opportunities.

Additionally, many communities in Virginia have adaptive recreation programs that provide opportunities for individuals with disabilities to participate in sports, arts, and other leisure activities. Consider the proximity of potential placements to these programs and the facility's willingness to support participation in such activities.

4. Proximity to Family and Medical Care

Balancing the desire for family involvement with access to specialized medical care is a crucial consideration in placement decisions. Virginia's diverse geography, from urban centers to rural communities, can present challenges in finding the right balance.

For many families, the ability to visit regularly and remain involved in their loved one's care is paramount. However, this must be weighed against the need for access to specialized medical care, particularly for individuals with complex health conditions.

In Virginia, specialized medical services are often concentrated in urban areas, particularly around major medical centers such as those in Richmond, Charlottesville, and Northern Virginia. If an individual requires frequent access to specialists or complex medical treatments, proximity to these medical hubs may be necessary.

On the other hand, rural areas of Virginia may offer more affordable housing options and a quieter lifestyle that some individuals prefer. Some rural communities have developed innovative programs to address healthcare access issues, such as telemedicine initiatives that can provide some level of specialized care remotely.

Families should consider the long-term sustainability of the chosen location. This includes thinking about how the individual's needs may change over time, as well as how the ability of family members to provide support or visit regularly may evolve as they age.

5. Cost and Funding Options

Understanding the cost implications and available funding options is critical when advising clients on residential placement decisions. Virginia offers several funding mechanisms for long-term care, each with its own eligibility criteria and coverage limitations.

a. Private Pay

For families considering private pay options, it's crucial to discuss the long-term sustainability of this approach. The cost of residential care can be substantial, and it's important to project these costs over the expected lifespan of the individual.

In Virginia, the cost of care varies significantly depending on the level of care and geographic location. As of 2023, the median annual cost for a semi-private room in a nursing home in Virginia was around $110,964, while assisted living facilities averaged about $72,600 per year.[15] These costs tend to be higher in urban areas and lower in rural regions.

When advising clients on private pay options, consider discussing strategies such as long-term care insurance, reverse mortgages, or the strategic use of assets to fund care while potentially preserving eligibility for future public benefits.

b. Medicaid-Funded Options

Virginia offers several Medicaid waiver programs that can fund residential services for eligible individuals. These include:

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver: This waiver can provide funding for assisted living facilities and adult foster care homes for individuals who meet nursing facility level of care criteria.

- Community Living (CL) Waiver: This waiver serves individuals with developmental disabilities and can fund services in group homes and other community-based settings.

- Family and Individual Support (FIS) Waiver: Similar to the CL Waiver, this program serves individuals with developmental disabilities but is designed for those with less intensive support needs.

c. Housing Vouchers and Subsidies

Virginia offers several housing assistance programs that can help make residential options more affordable:

[15] *See* Genworth Cost of Care Survey, https://www.genworth.com/aging-and-you/finances/cost-of-care.

- Section 8 Housing Choice Voucher Program: Administered by local housing authorities throughout Virginia, this federal program provides rental assistance to low-income individuals, including those with disabilities.

- Virginia Housing Development Authority (VHDA) Rental Unit Accessibility Modification Grant: This program provides funding to make rental units accessible for individuals with disabilities.

- Virginia's Livable Home Tax Credit: While not a direct housing subsidy, this program offers tax credits for the purchase or retrofitting of accessible homes, which can make homeownership more feasible for some individuals with disabilities.

When advising clients on housing options, investigate the availability of these programs in their local area and assist them in navigating the application processes.

D. Person-Centered Planning

Choosing the right residential placement for an individual with disabilities involves careful consideration of numerous factors, from the level of care needed to financial sustainability. Our role is to guide families through this complex decision-making process, providing comprehensive information about available options, legal considerations, and funding mechanisms. By taking into account the unique aspects of Virginia's long-term care system and the individual needs of each client, we can help ensure that families make informed decisions that promote the well-being, dignity, and quality of life of their loved ones with disabilities.

Regardless of the residential option chosen, person-centered planning is paramount. The individual with the disability should be involved in the decision-making process to the greatest extent possible, ensuring that their preferences, goals, and desires are central to the planning process. By taking this comprehensive approach, the dignity, independence, and quality of life of loved ones with disabilities is maintained.

III. Decision Making

Special needs planning also addresses a variety of legal issues to ensure that individuals with disabilities receive appropriate care and protection. Among the most critical aspects is surrogate- or supported-decision making.

A. Guardianship & Conservatorship

Guardianship and conservatorship is a vital legal mechanisms designed to protect individuals who are unable to make decisions for themselves due to incapacity. In Virginia, guardianship refers to the legal authority granted to a person, known as the guardian, to make decisions about the ward’s personal affairs, including health care, living

arrangements, and general well-being. Virginia law provides for both "full" and "limited" guardianship. Full guardianship, as outlined in § 64.2-2000 of the Virginia Code, involves comprehensive authority over all personal and medical decisions, whereas limited guardianship allows the court to grant authority only over specific areas as determined necessary by the court. This nuanced approach can be particularly beneficial when the individual retains some decision-making capacity but requires assistance in certain areas. It is essential for attorneys to assess which form of guardianship best balances protection with personal autonomy.

Conservatorship involves the management of an individual's financial affairs. A conservator is appointed by the court to handle financial decisions, manage assets, and address legal and financial matters. Like guardianship, conservatorship can be full or limited, depending on the extent of the individual's incapacity and the specific needs that arise. Virginia law mandates that the court closely supervise the conservator's actions to prevent abuse and ensure proper management of the individual's estate.

B. Powers of Attorney

The power of attorney (POA) is another essential tool in special needs planning in Virginia. Under § 64.2-1600 of the Virginia Code, a durable power of attorney allows an individual to designate an agent who can act on their behalf in financial or legal matters should they become incapacitated. The durable POA remains effective even if the principal becomes incapacitated, providing a crucial mechanism for managing affairs in times of need. When working with clients with disabilities, or their families, incorporating provisions in the power of attorney to ensure advanced planning for such individual is imperative.

C. Supported Decision Making

Supported decision-making is a process whereby individuals with disabilities receive assistance from trusted supporters to understand the nature of decisions they need to make, consider the available options, and communicate their choices to others. In 2021, the Virginia General Assembly passed legislation formally recognizing supported decision-making agreements.[16] The Virginia Code defines a supported decision-making agreement as "an agreement between a principal and a supporter that sets out the specific terms of support to be provided by the supporter, including (i) helping the principal monitor and manage his medical, financial, and other affairs; (ii) assisting the principal in accessing, obtaining, and understanding information relevant to decisions regarding his affairs; (iii) assisting the principal in understanding information, options, responsibilities, and consequences of decisions; and (iv) ascertaining the wishes and decisions of the principal regarding his affairs, assisting in communicating such wishes and decisions to other persons, and advocating to ensure the wishes and decisions of the principal are implemented."[17]

[16] Va. Code Ann. § 37.2-314.3 (2021).
[17] *Id.*

The statute contemplates that the Virginia Department of Behavioral Health and Developmental Services (DBHDS) will develop and implement a program to educate individuals, families, and professionals on supported decision-making agreements.[18] DBHDS is tasked with developing training, model agreement forms, and protocols to prevent abuse and exploitation.[19] The Department must also collect data and report annually to the Governor and General Assembly on utilization of supported decision-making agreements in the Commonwealth.[20]

The Code defines the key roles in a supported decision-making agreement as follows:

- Principal - The adult with an intellectual or developmental disability who enters into the agreement.

- Supporter - A person chosen by the principal to provide decision making assistance per the terms of the agreement. There can be multiple supporters.[21]

A supported decision-making agreement is not a court-ordered document and does not require a finding of incapacity. I contrast, Virginia law makes clear that a supporter has no legal authority to make decisions for the principal. Rather, a supporter's role is limited to providing support to enable the principal to make their own informed choices. The principal retains all legal decision-making authority.[22]

IV. Navigating Available Resources

The challenges of navigating the healthcare system and securing essential benefits can feel daunting, especially for those living with disabilities. However, a wealth of federal programs and community resources exist to support individuals with disabilities and their caregivers.

A. Federal Benefits

1. Supplemental Security Income (SSI)

At the federal level, the Supplemental Security Income (SSI) program stands as a vital safety net for individuals with disabilities. The SSI program is designed to provide a basic level of financial assistance to individuals with limited means, helping to cover the costs of food and shelter. To qualify for SSI, an applicant must meet the Social Security Administration's strict definition of disability, which requires the presence of a severe, long-term physical or mental impairment that significantly limits one's ability to work. Additionally, applicants must have limited income and resources, with specific guidelines

[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.*

around countable versus non-countable assets and the impact of in-kind support and maintenance.[23]

Applicants must have "countable" income[24] and resources[25] below specific thresholds set by the government. Countable income typically includes wages, Social Security benefits, and other forms of regular monetary assistance, while countable resources encompass cash, savings accounts, investments, and certain real estate holdings. However, the SSI program also recognizes "non-countable" assets, such as a primary residence, household goods, and certain types of life insurance policies, which are excluded from the resource calculation. Understanding the nuances of countable versus non-countable assets is crucial, as it can mean the difference between qualifying for or being denied SSI benefits.

2. Social Security Disability Insurance (SSDI)

For individuals with disabilities who have a substantial work history, Social Security Disability Insurance (SSDI) can provide a critical source of financial support. Unlike the Supplemental Security Income (SSI) program, which is needs-based, SSDI eligibility is determined by an applicant's prior employment and the contributions they have made to the Social Security system.

While SSI is a needs-based program, to qualify for SSDI, an individual must have earned a certain number of work credits, which are based on their total yearly income. The "recent work test" and "duration of work test" ensure that the applicant has maintained a consistent work history prior to the onset of their disability. The recent work test requires that the individual have worked for a certain period of time within a specific timeframe, while the duration of work test ensures that the individual has worked for a sufficient number of years over the course of their lifetime. These eligibility criteria are designed to demonstrate that the applicant has a proven track record of contributing to the Social Security system before becoming disabled. By meeting these work history requirements, individuals can access SSDI benefits, which can provide a more substantial monthly payment compared to the SSI program. However, it's important to note that SSDI benefits may impact other means-tested programs,

Additional benefits are available for adult dependent children. Specifically, the Childhood Disability Benefits (CDB) program, which provides assistance to adult children with disabilities whose parents have a work history. Adult children with disabilities can

[2323] In-kind support and maintenance is unearned income that SSI recipients receive in the form or food and shelter. Effective September 30, 2024, in-kind support and maintenance will only include shelter-related expenses. *See* 89 FR 21199. The effect of in-kind support and maintenance is a reduction or either one-third or one-third plus twenty dollars of the maximum monthly SSI payment depending on the living arrangement.

[24] Income must not exceed the annual substantial gainful activity amount ($1,470 per month in 2024) to be considered disabled. Income will be reduced $1 for $1 after a $20 disregard for any unearned income, and there will be a $1 for every $2 of income earned after a $65 disregard. In-kind support and maintenance rules will apply.

[25] Countable resources must be below $2,000 as of the first day of the month.

receive SSDI benefits based on a parent's work record if they meet specific criteria. To qualify, the adult child must be disabled and have become disabled before age 22. The amount of benefits an eligible adult child can receive is based on the disabled parent's earnings record and is generally 50% of the parent's primary insurance amount. Additionally, eligible adult children can receive up to 75% of the deceased parent's primary insurance amount (PIA) as a survivor benefit.[26] Note such amounts may be decreased based on family maximums imposed by the Social Security Administration.[27]

3. Medicare

In addition to the core federal benefits of SSI and SSDI, Medicare and Medicaid play pivotal roles in supporting individuals with disabilities. Those who qualify for both Medicare and Medicaid, known as "dual eligibles," can access a comprehensive suite of healthcare services and resources, including coverage for hospitalization, physician visits, prescription medications, and long-term care services.

Generally, individuals become eligible for Medicare when they turn 65, provided they have been a U.S. citizen or legal resident for at least five years and are either receiving Social Security benefits or are eligible for them. Eligibility also extends to those under 65 who qualify due to a disability, having received Social Security Disability Insurance (SSDI) for 24 months. Additionally, certain conditions, such as End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS), can trigger eligibility regardless of age.

Medicare Part A and Part B form the cornerstone of the Medicare program, providing essential health coverage for eligible seniors and certain younger individuals with disabilities. Medicare Part A, also known as Hospital Insurance, covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health services. Beneficiaries typically do not pay a premium for Part A if they or their spouse have paid Medicare taxes for at least 40 quarters. However, there are deductibles and coinsurance costs associated with hospital stays, which can be significant for extended periods.

Medicare Part B, or Medical Insurance, complements Part A by covering outpatient services, physician visits, preventive care, and some home health services not covered by Part A. Beneficiaries usually pay a monthly premium for Part B, which is adjusted based on income. In addition to the premium, there is an annual deductible and coinsurance costs, such as 20% of the Medicare-approved amount for most services. Understanding these costs is vital for financial planning and avoiding unexpected expenses.

For those needing prescription drug coverage, Medicare Part D offers a range of plans provided by private insurers. These plans vary in terms of premiums, formularies, and coverage rules. Beneficiaries can select a Part D plan that best meets their medication needs, but it's important to enroll during the Initial Enrollment Period to avoid

[26] https://www.ssa.gov/pubs/EN-05-10085.pdf.
[27] *Id.*

late enrollment penalties. Drug plans are distinct from Medicare Parts A and B and require separate enrollment, with varying costs depending on the chosen plan and income level.

Medicare Supplement Insurance, commonly known as Medigap, is another option that helps cover out-of-pocket costs not covered by Parts A and B, such as deductibles, coinsurance, and copayments. Medigap plans are standardized and sold by private insurance companies, with each plan offering different levels of coverage. Choosing the right Medigap plan can help mitigate the financial burden of healthcare expenses, though it involves additional premiums and considerations of existing coverage needs.

Medicare Advantage Plans, or Part C, present an alternative to Original Medicare, combining coverage from Part A, Part B, and often Part D into a single plan. Offered by private insurers, these plans may include extra benefits such as vision, dental, and hearing services. They typically require beneficiaries to use a network of providers and may have different cost structures, including copayments and coinsurance. While Medicare Advantage Plans can offer comprehensive coverage and potentially lower out-of-pocket costs, beneficiaries must carefully compare plans to ensure they align with their healthcare needs and financial situation.

Furthermore, the Medicare Savings Programs, including the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) programs, and Qualified Disabled and Working Individuals (QDWI), offer crucial assistance in covering Medicare premiums, deductibles, and co-payments for eligible individuals. Each program has different eligibility criteria and benefits, tailored to varying income levels and financial situations.

Eligibility for Medicare Savings Plans is primarily based on income and asset limits, which vary by state. Generally, applicants must have incomes below 150% of the Federal Poverty Level (FPL) and meet asset limits set by their state. For example, as of 2024, the income limit for a single individual to qualify for QMB is around $1,430 per month, and for SLMB, it is approximately $1,721 per month. Assets must typically be below $9,090 for individuals or $13,630 for couples, although some states have higher thresholds. It's important for applicants to check specific state guidelines, as the eligibility requirements can differ slightly.

Coverage under Medicare Savings Plans includes help with premiums and cost-sharing associated with Medicare Part A and Part B. The QMB program covers the full Part A and Part B premiums, as well as deductibles, coinsurance, and copayments. The SLMB and QI programs assist with Part B premiums only, with SLMB covering the full premium and QI providing partial assistance. The QDWI program helps pay the Part A premiums for disabled individuals who are working. Applying for MSPs can significantly reduce out-of-pocket costs, making Medicare more affordable for those with limited financial resources.

4. Medicaid

Medicaid is a vital program that provides health coverage to millions of low-income Americans, including many seniors and individuals with disabilities. Understanding the nuances of Medicaid is crucial, as it can significantly impacts access to healthcare services and long-term care options. Medicaid encompasses a range of programs designed to address different needs and populations, with three major components being the Children's Health Insurance Program (CHIP), Expanded Medicaid, and the Aged, Blind, and Disabled (ABD) program.

The Children's Health Insurance Program (CHIP) is aimed at providing health coverage to children from low- and moderate-income families who do not qualify for Medicaid but cannot afford private coverage. Eligibility for CHIP varies by state, but generally, it covers children up to age 19. In many states, CHIP can extend coverage to children in families with incomes up to 300% of the Federal Poverty Level (FPL). CHIP benefits typically include routine check-ups, immunizations, doctor visits, prescriptions, dental and vision care, and hospitalizations.

Expanded Medicaid, a provision of the Affordable Care Act, allows states to broaden Medicaid eligibility to individuals with incomes up to 138% of the FPL, regardless of their family status or health condition. This expansion aims to close the coverage gap for adults who cannot afford private insurance. Each state has the option to implement this expansion, resulting in variations in coverage and eligibility across the country.

The Aged, Blind, and Disabled (ABD) program provides health coverage for elderly individuals (aged 65 or older), individuals who are blind, and those with disabilities. Eligibility for the ABD program is determined by income and asset limits, which can vary by state. Generally, individuals must meet the federal income and asset requirements, which include having incomes below the FPL and limited resources. For 2024, the income limit for ABD eligibility is income for a single resident in Virginia is $1,004 per month[28] for for basic coverage and $2,829 per month for long-term care services, with asset limits of $2,000. These thresholds can be adjusted based on specific state policies.

One of the key benefits of the ABD program is its comprehensive coverage, which includes hospital and medical services, prescription drugs, and long-term care. This program is essential for individuals with disabilities who need assistance with daily living activities and cannot afford the high costs of long-term care. Medicaid also offers long-term care services, such as nursing home care and home and community-based services (HCBS), which are critical for maintaining quality of life for those with significant needs.

B. Non-Government Resources

While federal benefits provide a critical foundation, the true strength of the disability support system lies in the vibrant network of local and community-based resources. Disability advocacy organizations, independent living centers, and specialized service providers can offer invaluable guidance, from navigating the complex application

[28] Note that the income limit is $1,363 per month if an individual is married. When two spouses are applying for long-term care services, the income limit is $5,658. The asset limit for a married couple is $3,000.

processes for federal benefits to securing essential assistive technologies and home modifications. These local resources can make a profound difference in empowering individuals to live independently, pursue educational and employment opportunities, and actively participate in their communities.

Equally important are the support groups and peer-to-peer networks that connect individuals with disabilities and their caregivers. These forums provide a vital source of emotional support, practical advice, and a sense of community, enabling individuals to share their experiences, learn from one another, and find solace in the knowledge that they are not alone in their journey.

V. State-specific Benefits

Medicaid Waiver Programs are a cornerstone of special needs planning, offering a range of services designed to meet the diverse needs of individuals with disabilities. Among these, the Home and Community-Based Services (HCBS) waivers stand out for their flexibility and breadth. These waivers allow individuals to receive services such as personal care, which includes assistance with activities of daily living like bathing and dressing. Additionally, respite care is available to provide temporary relief to caregivers, giving them a much-needed break while ensuring that their loved ones continue to receive appropriate care. Home modifications are also covered, enabling families to make necessary adjustments to their living spaces, such as installing ramps or grab bars, to ensure safety and accessibility.

A. Developmental Disability Waivers

The Developmental Disabilities waiver program in Virginia, known as the My Life My Community Waiver, specifically targets individuals with developmental disabilities, including intellectual and developmental disabilities.[29] This waiver provides services like case management, behavioral supports, and community-based services tailored to individual needs. For example, individuals might receive assistance with daily living skills, therapeutic services, or support for participating in community activities. These services are designed to help individuals lead more independent and fulfilling lives while remaining integrated into their communities.

There are three My Life My Community waivers: There are three waivers available for individuals with a developmental disability: the Building Independence Waiver (BI), the Family and Individual Supports Waiver (FI), and the Community Living (CL) Waiver. Each of these waivers is tailored to different levels of need and offers a variety of services to support individuals with developmental disabilities.

The Building Independence Waiver (BI) is particularly focused on helping individuals transition to living independently. This waiver is ideal for individuals who are capable of living in a more self-sufficient setting but need some level of support to successfully make

[29] Mental illness is not a developmental disability and as a result if the only disability is mental illness the waiver is a viable option for services.

this transition. Services under the BI Waiver include assistance with community integration, support for acquiring independent living skills, and access to job training and employment services. This waiver is designed to empower individuals to develop the skills necessary for independent living, ultimately reducing their reliance on institutional care.

The Family and Individual Supports Waiver (FI) provides a more flexible range of services designed to support individuals living with their families or in their own homes. This waiver focuses on enhancing the quality of life for individuals who need support but do not require the more intensive services provided by other waivers. Services include respite care to provide temporary relief for family caregivers, personal assistance, and community engagement activities. The FI Waiver is particularly beneficial for families seeking to maintain their loved ones in a home environment while accessing the support needed to address their unique needs.

The Community Living Waiver (CL) is geared towards individuals who require a higher level of support to live in community settings, such as group homes or supervised living arrangements. This waiver offers a broad range of services, including 24-hour personal care, habilitation services, and support for daily living activities. The CL Waiver is designed for individuals who may need ongoing, intensive assistance to manage their daily routines and engage meaningfully in their communities. It aims to provide a supportive environment that fosters independence while ensuring that individuals receive the care and assistance they need.

B. Commonwealth Coordinated Care Plus (CCC+)

The Aged and Disabled waiver, now known as the CCC+ Waiver, is aimed at older adults and individuals with physical disabilities who require assistance to live independently. One of the primary goals of the CCC+ Waiver is to provide enhanced coordination of care, ensuring that individuals receive the right mix of services to support their health and well-being while remaining in their homes and communities. The CCC Plus Waiver provides supports and service options such as personal care, respite, private duty nursing, adult day health care, assistive technology and environmental modifications.

One of the key services offered under the CCC+ Waiver is personal care assistance. This includes help with activities of daily living (ADLs) such as bathing, dressing, grooming, and mobility. Personal care services are tailored to the specific needs of each individual, allowing for a customized approach to support that helps maintain personal hygiene and overall comfort.

Another essential service under the CCC+ Waiver is respite care. This service is designed to provide temporary relief for primary caregivers who may need a break from their caregiving responsibilities. Respite care can be provided in various settings, including in-home care or short-term stays at a facility. This service not only supports the well-being of caregivers by giving them a chance to rest and recharge but also ensures that individuals continue to receive appropriate care and supervision during these periods.

The CCC+ Waiver also includes case management services, which are crucial for coordinating care and accessing additional supports. Case managers work closely with individuals and their families to develop and implement a personalized care plan that addresses all aspects of the individual's needs. This might involve coordinating medical care, arranging for home modifications, or connecting individuals with community resources. The goal of case management is to ensure that all necessary services are integrated effectively and that individuals receive a holistic approach to their care.

The former Technology Assisted Waiver was incorporated into the CCC+ Waiver. It was designed to help individuals access and utilize assistive technology. This can include devices like communication aids, mobility equipment, and adaptive computer technology. For many, this technology can make a significant difference in their ability to perform daily tasks and engage more fully in their communities.

Additionally, the CCC+ Waiver covers various other supports aimed at enhancing quality of life and maintaining independence. These include home and vehicle modifications to improve accessibility and safety, as well as assistive technology to support communication and mobility. The waiver also provides access to therapeutic services, such as physical therapy and occupational therapy, which can be vital for individuals recovering from injury or managing chronic conditions. By offering a broad spectrum of services, the CCC+ Waiver ensures that individuals receive comprehensive support tailored to their unique needs and preferences.

C. Traumatic Brain Injury Services

In response to House Bill 680, the Virginia Department of Medical Assistance Services (DMAS), in collaboration with stakeholders, is developing a targeted case management (TCM) service specifically for individuals with severe traumatic brain injury. This initiative, mandated by the bill, involves updating the State Plan for Medical Assistance to include Medicaid payment provisions for these specialized case management services. DMAS's implementation of the brain injury TCM will proceed in two phases: provider enrollment began in August 2023, and services began in January 2024. The program is designed to provide access to community resources.

D. Employment Services

Vocational Rehabilitation Services in Virginia play a pivotal role in helping individuals with disabilities achieve meaningful employment and economic independence. Administered by the Virginia Department for Aging and Rehabilitative Services (DARS), these services are designed to address various barriers to employment through a tailored approach. By providing comprehensive support, including job training, placement assistance, and access to assistive technology, Virginia aims to enhance the employment prospects and quality of life for individuals with disabilities.

A foundational aspect of these services is the creation of an Individualized Plan for Employment (IPE). This plan is developed collaboratively between the individual and a

vocational counselor, detailing specific employment goals and the strategies needed to achieve them. The IPE is customized to each person's strengths, interests, and career objectives. It may include objectives such as obtaining specific job skills, advancing in a current job, or pursuing additional education or training. The personalized nature of the IPE ensures that each individual's unique needs are met, setting a clear pathway toward successful employment outcomes.

Job training and placement services are integral to the vocational rehabilitation process. These services offer practical support, including skills development and job readiness training. Individuals may receive training tailored to their specific career goals, such as acquiring new technical skills or gaining industry certifications. Placement services assist in connecting individuals with suitable job opportunities, providing support with resume writing, interview preparation, and job search strategies. By focusing on both training and placement, Virginia's vocational rehabilitation services help individuals secure and maintain meaningful employment.

Medicaid Works is a vital program within Virginia's vocational rehabilitation framework, designed to address concerns about maintaining Medicaid benefits while pursuing employment. Eligibility for Medicaid Works is generally based on the individual's need for Medicaid coverage and their intent to work. To qualify, individuals must meet certain income and asset criteria, which are typically aligned with Medicaid eligibility guidelines. Specifically, in 2024 enrollees may earn up to $75,000 and save up to $45,976 of their earnings; however total countable income cannot exceed $1,732 per month for an individual or $2,351 for a couple and resources may not exceed $2,000 if single ($3,000 if a couple).[30] Medicaid Works allows individuals with disabilities to retain their Medicaid benefits even as they earn income, thereby alleviating the fear of losing critical health coverage and supporting a smoother transition into the workforce.

Assistive technology is another key component of Virginia's vocational rehabilitation services. This technology includes devices and software that assist individuals in performing job-related tasks and improving their productivity. Examples of assistive technology include adapted computer systems, specialized communication devices, and mobility aids. By providing access to these tools, the program helps individuals overcome physical or cognitive barriers, enabling them to participate fully in the workplace and achieve their employment goals.

Centers for Independent Living (CILs) and local disability resource centers are essential in supporting Virginia's vocational rehabilitation efforts. CILs offer a wide range of services, including skills training, advocacy, and support for independent living.[31] They work closely with vocational rehabilitation programs to ensure that individuals receive a comprehensive approach to employment support. Disability resource centers serve as crucial hubs for information and guidance, helping individuals navigate available services and connect with necessary resources. Together, these centers enhance the

[30] https://coverva.dmas.virginia.gov/media/c43n2s2l/medicaid-works-fact-sheet-en-01-18-24-final.pdf.
[31] https://vacil.org/.

effectiveness of vocational rehabilitation services by providing additional support and resources tailored to the needs of individuals with disabilities.

E. Maximizing Benefits

In special needs planning, coordinating benefits is a critical aspect of ensuring that individuals with disabilities receive the full support they need without jeopardizing their eligibility for essential programs. Understanding how various benefits interact with each other is vital for effective planning. Many individuals with special needs rely on a combination of federal, state, and local programs, each with its own eligibility criteria and benefit structures. For instance, Medicaid, Supplemental Security Income (SSI), and various state-specific programs can overlap in their support but may have different rules regarding income and asset limits.

One of the most significant challenges in coordinating benefits is avoiding the so-called "benefit cliffs," where a modest increase in income or assets could result in a sudden and substantial loss of benefits. For individuals with disabilities, such a loss can have severe consequences, including the loss of health coverage, housing assistance, or other crucial supports. To mitigate this risk, elder law attorneys can employ strategies such as utilizing ABLE accounts and special needs trusts.

In practice, coordinating benefits involves a detailed analysis of each client's situation, including their income, assets, and the specific programs they rely on. Attorneys must be vigilant in monitoring any changes in clients' financial circumstances and how these changes might impact their benefits. Ultimately, effective coordination of benefits requires a proactive and informed approach. Elder law attorneys must stay updated on changes in legislation and program rules to provide the best possible advice and support. By understanding the interactions between different benefits and employing strategies to prevent benefit cliffs, attorneys can help individuals with special needs navigate their financial and support systems more effectively, ensuring they continue to receive the comprehensive assistance they need.

Virginia House Bill 908 (HB 908), introduced in the 2024 legislative session, represents a significant advancement in the state's approach to special needs planning and support. This bill focuses on expanding access to critical services for individuals with disabilities by enhancing eligibility criteria. Specifically, HB 908 amends financial eligibility for Development Disability waiver by disregarding any Social Security Disability Insurance (SSDI) income above the maximum monthly Supplemental Security Income (SSI).[32] However, the Bill does include SSDI for purposes of determining an individual patient pay obligation. This Bill will remain in effect for two years.

VI. Emotional and Family Considerations

[32] https://lis.virginia.gov/cgi-bin/legp604.exe?241+sum+HB908#:~:text=The%20bill%20requires%20the%20Department,such%20Social%20Security%20Disability%20Insurance.

A. Supporting the Individual with Special Needs

At the heart of special needs planning is person-centered planning. This approach involves actively including the individual in decision-making processes, respecting their autonomy, and focusing on their strengths and preferences. By engaging the individual in discussions about their future, the planning process is aligned with their desires and needs. This not only fosters a sense of control and self-determination but also results in more personalized and effective planning outcomes.

Encouraging self-advocacy is another critical element of supporting individuals with special needs. Teaching self-advocacy skills empowers individuals to speak up for themselves, make informed choices, and assert their rights. This can be achieved through education and training that enhances their ability to navigate various systems and services. Additionally, supporting participation in advocacy groups helps individuals connect with a broader community of peers and allies, further strengthening their capacity to advocate for their own needs and preferences.

Building a robust support network is essential in ensuring that individuals with special needs have access to the resources and assistance they require. Identifying key supporters, such as family members, friends, and professionals, is the first step. These individuals can provide emotional support, practical help, and guidance. Creating a circle of support, a formal or informal network of people who are committed to the individual's well-being, helps to ensure that they have a reliable and comprehensive support system in place.

B. Addressing Family Dynamics

Family dynamics play a significant role in the planning process, particularly when it comes to involving siblings and addressing their roles. Sibling involvement and education are vital for ensuring that all family members are informed and engaged in future care planning. Siblings may have specific insights into the needs and preferences of their brother or sister, and their involvement can help in formulating a well-rounded plan. Understanding current support roles and preparing for future responsibilities can help prevent conflicts and ensure that caregiving duties are equitably distributed.

Balancing the needs of all family members is another critical aspect of special needs planning. Caregiver stress is a common challenge, as the demands of caregiving can take a toll on mental and physical health. Addressing caregiver stress involves recognizing the signs of burnout and providing strategies for managing stress effectively. Additionally, maintaining healthy family relationships requires open communication, mutual support, and a recognition of each member's needs and contributions. Ensuring that all family members feel valued and heard helps to foster a supportive and cohesive family environment.

Planning for caregiver respite and support is essential to prevent burnout and ensure long-term sustainability of care. Respite care options, including short-term relief

provided by professional caregivers or temporary care settings, allow primary caregivers to take necessary breaks and recharge. Caregiver support groups and resources offer emotional support, practical advice, and a sense of community for those involved in caregiving. These resources can be invaluable in helping caregivers navigate the challenges they face and maintain their well-being.

Eliminating (mostly) the Need for Gray Divorce in Long-Term Care Planning and Crisis Contexts: QDROs, ERISA, and Marrieds*

Also, VRS is now fair game.

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PREAMBLE/BACKGROUND:

Considerations:

- In a Medicaid crisis, is it less expensive to pay out of pocket for urgently needed long term care, or to try to protect some of the assets for a spouse still well enough to live at home?
    - For attorney – cost-benefit analysis
    - For client – social, emotional, medical, etc analysis
        - ESPECIALLY for a long-married couple.
        - ESPECIALLY ESPECIALLY when grey divorce (Medicaid divorce) is on the table
- Why consider grey divorce?
    - Need to transfer *retirement* assets to community spouse (CS)in order to protect the assets and provide financial security to CS, without paying obscene taxes
    - Need to provide income to CS to replace institutionalized spouse's (IS's) payment to the facility or caregivers
- For our purposes:

- CS and IS married 62 years. IS is 93 years old, needs assistance with multiple ADLs, and has been medically qualified for LTSS through the local social services department. CS is 85 and healthy as an ox.
- Resources are not unlimited:
    - Home just in IS's name (because a "helpful" neighbor said that was how to protect it from "the government")
    - $250,000 in non-qualified funds, mostly in joint name (because they didn't entirely trust the neighbor)
    - IS has an individual 401(k) from his sign-painting business that they started after retiring from their major manufacturing job after 30 years of pristine service. Individual(k) has approximately $125,000 in it. Yes, they were told by their financial advisor to roll it into an IRA. No, they haven't gotten around to it yet. Yes this number was picked because it is slightly under the maximum CSRA. Hey, I don't write the rules, but VACLE asked me to write the scenario.
    - Income:
        - IS has a defined pension from the major manufacturing job of $1,700/month.
        - IS has Social Security of $1,300/month
        - CS has Social Security of $700/month
        - CS has defined pension of $400/month from
- Medical qualification established a September 1, 2020 snapshot date which, coincidentally, is the valuation date of all of the above figures.

- Because we are clever, highly advanced elder law attorneys, when all is said and done, here will be the result, before doing further pre-planning for CS:
    - Home is in CS's sole name
    - CS protected the NQ assets, pretty much all of them, through the use of a promissory note and other schemes (not discussed herein)
    - CS now owns a $125,000 IRA, from IS's Individual(k)
    - CS now receives IS's pension income in addition to their SS and pension.
    - IS only pays $1,300 social security, less appropriate deductions for Medicare supplement, PNA, etc.
- HOW DID WE ACHIEVE THIS MARVEL?

1) QDRO – What is it?

a) Qualified domestic relations order is a tool used, traditionally in the context of a divorce, to transfer ERISA protected retirement assets from one spouse to another.

i) Generally, as part of an asset settlement agreement

(1) Transfer from spouse 1 to spouse 2

(2) E.g.: S1 has separate retirement assets of $500,000 in a 401(k). Under the terms of the couple's settlement agreement, S1 is to transfer to S2 $250,000 of those assets. How? Using a QDRO.

ii) QDRO is an order from the state court to the Administrator of the retirement plan (e.g. IBM, Fidelity, PlanAmerica, etc.) saying "please transfer assets under the following terms."

b) Why is a QDRO necessary? Why can't S1 just transfer to S2? Or, for our purposes, IS to CS.

i) Taxable event – *see generally* 26 USC § 401 (26 USC shall hereinafter be referred to as the Internal Revenue Code, or IRC) (APPENDIX, DOC 1 ("App 1")).

(1) Plus, under 59 ½? 10% penalty! Kaboom!

ii) May also be (almost certainly is) prohibited by the Summary Plan Description, the document governing the retirement plan's management.

c) But why is a QDRO, specifically, necessary?

2) ERISA – Employee Retirement Income Security Act of 1974

a) Covers certain retirement plans – NOT ALL PLANS

i) Covers

(1) 401(k)

(2) 403(b)

(3) Defined pension plans

ii) Does NOT cover

(1) IRAs – BUT SEE SEP IRAs under certain interpretations/arguments

(2) FERS

(3) CSRS

b) What is meant by "covers"? What does ERISA mean to me?

i) When originally enacted, ERISA was intended to protect retirement plan income from the alienation of a retiree's interest in their benefits. ERISA of 1974, Pub. L. No. 93-406, § 206(d)(1), 88 Stat. 823, 864 (1974), later codified into 29 USC § 1056 (§1056(d)(1), App 2)

(1) "Each pension plan shall provide that benefits provided under the plan may not be assigned or alienated."

(2) Retiree is called a "plan participant"

ii) So, great. Congress gave a way to protect assets and, as a reward for using the system, they deferred income taxes.

iii) But, again, it's 1974. What was about to change in the US? What was going on? Why might we need to "alienate" assets?

(1) Increased divorce rates

(2) Women's liberation & second wave feminism (thank goodness!)

(3) Altered expectations regarding marital partnership

(4) Transition to an overtly economic partnership under law

c) Men were still (are still) the primary owners of retirement wealth. The restriction on alienation HARMED DIVORCING SPOUSES, who were primarily women.

d) ERISA was too restrictive. So back to Congress for…

e) The Retirement Equity Act of 1984, Pub. L. No. 98-397, preamble, 98 Stat. 1426, 1426 (1984) ("REA")("An act to amend [ERISA] and the [IRC] of 1954 to . . . provide for ***greater equity*** under private pension plans for workers ***and their spouses*** and dependents . . . by taking into account . . . the substantial contribution to [the marital partnership] of spouses who work ***both in and outside the home***.") (App 3).

f) REA mitigated the harm caused by ERISA's strictures. REA later codified in 29 USC § 1056 as well (back to App 2).

g) REA:

i) "Paragraph (1) shall apply to the creation, assignment, or recognition of a right to any benefit payable with respect to a participant pursuant to a domestic relations order, ***except that paragraph (1) shall not apply if the order is determined to be a qualified domestic relations order***."

(1) "Paragraph (1)" is the prohibition against alienation.

ii) Such a domestic relations order is only "qualified" if it is awarding a plan benefit to an "alternate payee."

iii) "Alternate payee" means "any spouse, former spouse, child, or other dependent of a participant who is recognized by a domestic relations order as having a right to receive all, or a portion of, the benefits payable under a plan with respect to such participant." REA at Pub. L. No. 98-397, § 104(a)(3)(K) (App 2, p. 5, as 1056(d)(3)(K))

iv) This is the ERISA framework today. 29 USC § 1056(d)(3)(K)(2019) (toldja). *See Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 288 (2009)(App 4)(the bar against alienation "does not apply to qualified domestic relations orders.")

h) The Tax Code agrees

i) IRC § 414(p)(8) (2019) also defines an alternate payee to include both a "spouse" and a "former spouse" who may have "a right to receive all, or a portion of" plan benefits. (take my word for it, we won't look at this one again and it's 60 pages long)

Take a big fat step back. What is the usual usage of QDROs again?

Divorce.

What language allows that? Is it "spouse" or is it "former spouse"? Traditionally, Courts use QDROs in the context of equitable distribution and divorce. So wouldn't that mean the "former spouse"? What the heck does "spouse" mean?

3) The Department of Labor to the rescue!

a) We could sit and argue about whether "spouse" is an equivalent term to "former spouse," since at some point in the context of a divorce, there are two moments where, in the first, the person is a spouse and in the second, they are the former spouse. This has been suggested in investigating these issues. However, there is DOL guidance directly on point.

b) U.S. DEPT. OF LABOR, EMPLOYEE BENEFITS SECURITY ADMINISTRATION, *QDROS* – THE DIVISION OF RETIREMENT BENEFITS THROUGH QUALIFIED DOMESTIC RELATIONS ORDERS (2014) ("DOL Guidance")(App 5). – "Must a domestic relations order be issued as part of a divorce proceeding to be a QDRO?" That is, is "qualification" dependent on a divorce action?

i) The answer: a stunning and simple: "No"

(1) "A domestic relations order that provides for child support *or recognizes marital property rights* may be a QDRO, *without regard to the existence of a divorce proceeding[!!!!!!!]*. Such an order, however, must be issued pursuant to state domestic relations law and create or recognize the rights of an individual who is an 'alternate payee' (***spouse***, former spouse, child, or other dependent of a participant)." Emphasis added, obviously. DOL doesn't use the exclamation point, let alone seven of them.

c) DOL Guidance, therefore, adds another requirement – there must be state domestic relations law to effect the order.

d) This makes sense, of course. There must be some state law under which the QDRO is made, right? Otherwise, how do we get into court in the first place? Currently, there is no section in Va Code § 8.01 regarding "petition for QDRO for married couple." What the heck should we do? [VAELA public policy committee: don't get any ideas]

4) State Law Hurdles

a) DOL requires that a QDRO be issued pursuant to state domestic relations law.

b) In the context of a divorce, that's easy. You're already in court, you have a case file number, you have adverse parties, it's easy to see how you'd get an order.

c) *Sans* divorce, though, what is our "domestic relations law" hook? And what does Virginia think about all this?

d) Virginia agrees that, to have a QDRO, you need a domestic relations hook from state law:

e) *Griffin v. Griffin*, 62 Va. App. 736, 752 (Ct. App. 2014), *aff'd sub nom. Cowser-Griffin v. Griffin*, 289 Va. 189 (2015), U.S. Sup. Ct. *cert. denied* No. 14-1531, 2016 U.S. LEXIS 333, *1 (Jan. 11, 2016)(App 6).

i) *Griffin* court acknowledged that a current spouse can be the recipient of benefits under a domestic relations order, and explained the requirements for such an order to be "qualified" (hence the QDRO).

(1) A domestic relations order is any "order (including approval of a property settlement agreement) which – (I) relates to the provision of . . . ***marital property rights to a spouse,*** former spouse, child, or other dependent of a participant, and

(II) is made pursuant to a State domestic relations law." (citing 29 U.S.C. § 1056(d)(3)(B)(ii)(App 2).

5) Medicaid Hurdles

a) As with all things, context is king.

b) As a Medicaid tool, transferring assets in a 401(k) could of course be a useful tax-free way of accomplishing pre-approval planning.

i) Such assets would of course be exempt from transfer penalties under M1450 as a transfer between spouses. M1450.400(D) – "Transfer of any asset to the individual's spouse . . . does not affect eligibility for Medicaid payment of LTC services."(App 7)

ii) But what about transferring an income stream, e.g. a defined pension covered by ERISA?

(1) Must ensure that it is a transfer of a property interest in the pension, and not merely a transfer of the income itself, in order for Medicaid to accept that the transferred income stream is not available for the Medicaid recipient's patient pay.

6) Use of a Marital Agreement to Define the Property Interest Transferred

a) This does double duty – it provides the state domestic relations law "hook" to get the QDRO entered, AND it defines the transfer as a property interest such that Medicaid cannot touch the transferred income in most cases.

b) What does a Marital Agreement do, in terms of the domestic relations hook?

i) Section 20-155 of the Virginia Code governs marital agreements. Under that section:

(1) "[m]arried persons may enter into agreements with each other for the purpose of settling the rights and obligations of either or both of them, to the same extent, with the same effect, and subject to the same conditions, as provided in §§20-147 through 20-154 for agreements between prospective spouses, except that such marital agreements shall become effective immediately upon their execution." (App 8).

ii) Section 20-150, then, allows spouses who enter marital agreements to contract with respect to:

(1) "The tights and obligations of each of the parties ***in any of the property*** of either or both of them whenever and wherever acquired or located;

(2) "The right to buy, sell, use, ***transfer***, exchange, abandon, lease, consume, expend, assign, create a security interest in, mortgage, encumber, dispose of, or otherwise manage and control property;

(3) "The ***disposition of property upon*** separation, marital dissolution, death, or ***the occurrence or nonoccurrence of any other event***;

(4) "Spousal support;

(5) "The making of a will, trust, or ***other arrangement to carry out the provisions of the agreement***;

(6) "The ownership rights in and disposition of the death benefit from a life insurance policy;

(7) "The choice of law governing the construction of the agreement; and

(8) "Any other matter, including their personal rights and obligations, not in violation of public policy or a statute imposing a criminal penalty."

iii) Virginia law also has no requirement that there be independent consideration for such an agreement to be enforceable. *Shenk v. Shenk*, 39 Va. App. 161 (Ct. App. 2002)(App 10).

c) What, then, does our Marital Agreement need to say?

i) Agreement to transfer all property interest in, e.g., a pension plan from Spouse 1 to Spouse 2 (under 20-150(1),(2),(3))(App 9).

ii) Agreement to submit a draft QDRO to the Court to enforce and effectuate the transfer (under 20-150(5) – an "arrangement to carry out the provisions of the agreement")

(1) Remember that this is the only way to make a tax-free, penalty-free transfer – obtain a QDRO. The parties cannot self-execute this transfer. 29 U.S.C. § 1056(d)(App 2) states that plan benefits cannot be assigned or alienated *unless* a QDRO is entered

(a) This was not raised in either of our cases, but what if the Court had come back and said "just do an in-service withdrawal and take the penalties and pay the taxes?" What recourse?

(i) Seems to clearly fly in the face of the idea that spouses can contract to do whatever they want, but could also see a court saying "Do what you want, but there are penalties…."

(ii) (no one tell the judges)

d) Virginia, then, must enforce such a contract.

i) *Cooley v. Cooley*, 220 Va. 749, 752 (1980)(App 11) – "Marital property settlements entered into by competent parties upon valid consideration for lawful purposes are ***favored in the law*** and such ***will be enforces*** unless their illegality is clear and certain" (emphasis added).

ii) Marital agreements are just a specie of contract. "When a marital agreement is presented, a court applied 'the same rules of formation, validity and interpretation' used in contract law . . ." except that marital agreements need not be supported by consideration. *Shenk*, 39 Va. App. at 170, quoting *Smith v. Smith*, 3 Va. App 510, 513 (Ct. App. 1986) and citing Va. Code § 20-149 (premarital agreements "shall be enforceable without consideration").

iii) Remedies to enforce contract include equitable powers to require specific performance. *Griffin*, 62 Va. App. at 753-54(App 6). The *Griffin* court actually has a subject heading that reads: "C. The QDRO is ***the Tool*** by which State Courts ***Can Enforce Marital Property Settlements***"(emphasis added), and states that, "Generally, 'when a contract has been made, and either party refuses to perform the agreement, ***equity enforces the performance of the contract specifically***, by compelling the refractory party to fulfill his engagement according to its terms.'" *Id.* at 754 (emphasis added)(quoting *Dunsmore v. Lyle*, 87 Va. 391, 392 (1891). "Thus . . . the ***circuit court is responsible for enforcing [the agreement's] terms under state law***." *Griffin* at 754. It continues:

> When a party breaches the terms of a property settlement agreement [regarding] ERISA-governed accounts in accordance with the agreement, the ***only way for the circuit court to enforce the agreement is to issue a QDRO***. 29 U.S.C. § 1056(d)(3); *Kennedy*, 555 U.S. at 288[1] (ERISA prohibits assignment or alientation of benefits governed by the plan except in the case of a QDRO).
>
> …
>
> "State family law can . . . create enforceable interests in the proceeds of an ERISA plan, so long as those interests are articulated in accord with the QDRO provision's requirements." *Tise*, 234 F.3d at 420[2]; *see also Turner v. Turner*, 47 Va. App. 76, 79 (Ct. App. 2005)(this

[1] *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 288 (2009).
[2] *Trs. Of the Dirs. Guild of America-Producer Pension Benefits Plans v. Tise*, 234 F.3d 415, 420 (9th Cir. 2000).

> Court agreed with wide that the "QDRO simply was an administrative mechanism ***to effectuate the intent and purpose*** of the final decree's award").
>
> *Griffin*, 62 Va. App. at 754-55 (emphasis added).

iv) The only funny thing here, then, is that we don't have a "refractory party"; generally the parties can petition for the QDRO together. BUT, consider having one party refuse in order to make the petition something a court may more readily recognize, if it seems wise in your jurisdiction.

7) Technical Requirements for a QDRO – there are "only" eleven requirements

a) Section 1056(d)(3)(c)(ii) (App 2) defines a domestic relations order as:

i) Any judgment, decree, or order (including approval of a property settlement agreement)

ii) Which relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant, and

iii) Is made pursuant to a State domestic relations law (including a community property law)

b) Section 1056(d)(3)(c) further defines a qualified DRO as a DRO which:

i) Creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under a plan.

ii) Specifies the name and the last known mailing address of the participant and the name and mailing address of each alternate payee covered by the order.

iii) Specifies the amount or percentage of the participant's benefits to be paid by the plan to each such alternate payee, or the manner in which such amount or percentage is to be determined

iv) Specifies the number of payments or period for which such an order applies

v) Specified each plan to which such order applies (sometimes there are multiple participant plans)

vi) Does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan

vii) Does not require the plan to provide increased benefits (as determined on the basis of actuarial tables and values) AND

viii) Does not require the payment of benefits to an alternate payee which are required to be paid to *another* alternate payee under *another* order previously determined to be a qualified domestic relations order.

c) But here's the good news:

i) Just call your client's plan administrator. They will have a sample/template QDRO form. And guess what, they already know that a current spouse can be an alternate payee. It's just the Courts that don't know that yet.

8) Non-Medicaid Uses of the Married-Persons' QDRO

a) Delay RMDs – take advantage of a May-December marriage by transferring assets from old spouse to young spouse

b) Avoid withdrawal penalties – take advantage of a May-December marriage by transferring assets from *young spouse* to *old spouse*

c) Balance or transfer assets as part of an estate plan

d) Fund a Roth IRA

e) Liquidate 401(k) prior to 59 ½ without incurring a penalty

f) Access funds prior to Retirement

g) Get better returns through active management by your own financial advisor

h) Create self-directed IRAs

i) Reverse transfers from IRAs

  i) If neither spouse has an ERISA-based plan, but has IRA money, you can still get fancy and use this tool.

    (1) Create an LLC or other business for the client with the IRA

    (2) Have LLC or other business create an individual 401(k) plan (or SEP IRA??? SEP is cheaper, administratively)

    (3) Fund the 401(k) with the IRA assets

    (4) Have the client and spouse enter a marital agreement

    (5) Draft a QDRO and petition to have it entered

    (6) Send executed QDRO to plan administrator, who will transfer to alternate payee, who will deposit into IRA for alternate payee.

    (7) I will buy a kewpie doll for whoever sends me one of these. I just had one allllllllmost work, but the business crashed and burned during Covid.

j) More…?

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26 USCS § 401

Current through Public Law 116-155, approved August 8, 2020.

United States Code Service > TITLE 26. INTERNAL REVENUE CODE (§§ 1 — 9834) > Subtitle A. Income taxes (Chs. 1 — 6) > CHAPTER 1. Normal taxes and surtaxes. (Subchs. A — Z) > Subchapter D. Deferred compensation, etc. (Pts. I — III) > Part I. Pension, profit-sharing, stock bonus plans, etc. (Subpts. A — E) > Subpart A. General rules. (§§ 401 — 409A)

Notice

This section has more than one version with varying effective dates.

§ 401. Qualified pension, profit-sharing, and stock bonus plans. [Effective until December 31, 2020]

(a) Requirements for qualification. A trust created or organized in the United States and forming part of a stock bonus, pension, or profit-sharing plan of an employer for the exclusive benefit of his employees or their beneficiaries shall constitute a qualified trust under this section—

(1) if contributions are made to the trust by such employer, or employees, or both, or by another employer who is entitled to deduct his contributions under section 404(a)(3)(B) [*26 USCS § 404(a)(3)(B)*] (relating to deduction for contributions to profit-sharing and stock bonus plans), or by a charitable remainder trust pursuant to a qualified gratuitous transfer (as defined in section 664(g)(1) [*26 USCS § 664(g)(1)*]), for the purpose of distributing to such employees or their beneficiaries the corpus and income of the fund accumulated by the trust in accordance with such plan;

(2) if under the trust instrument it is impossible, at any time prior to the satisfaction of all liabilities with respect to employees and their beneficiaries under the trust, for any part of the corpus or income to be (within the taxable year or thereafter) used for, or diverted to, purposes other than for the exclusive benefit of his employees or their beneficiaries (but this paragraph shall not be construed, in the case of a multiemployer plan, to prohibit the return of a contribution within 6 months after the plan administrator determines that the contribution was made by a mistake of fact or law (other than a mistake relating to whether the plan is described in section 401(a) [*26 USCS § 401(a)*] or the trust which is part of such plan is exempt from taxation under section 501(a) [*26 USCS § 501(a)*], or the return of any withdrawal liability payment determined to be an overpayment within 6 months of such determination));

(3) if the plan of which such trust is a part satisfies the requirements of section 410 [*26 USCS § 410*] (relating to minimum participation standards); and

(4) if the contributions or benefits provided under the plan do not discriminate in favor of highly compensated employees (within the meaning of section 414(q) [*26 USCS § 414(q)*]).

For purposes of this paragraph, there shall be excluded from consideration employees described in section 410(b)(3)(A) and (C) [*26 USCS § 410(b)(3)(A)* and (C)].

(5) Special rules relating to nondiscrimination requirements.

(A) Salaried or clerical employees. A classification shall not be considered discriminatory within the meaning of paragraph (4) or section 410(b)(2)(A)(i) [*26 USCS § 410(b)(2)(A)(i)*] merely because it is limited to salaried or clerical employees.

(B) Contributions and benefits may bear uniform relationship to compensation. A plan shall not be considered discriminatory within the meaning of paragraph (4) merely because the contributions or benefits of, or on behalf of, the employees under the plan bear a uniform relationship to the compensation (within the meaning of section 414(s) [*26 USCS § 414(s)*]) of such employees.

(C) Certain disparity permitted. A plan shall not be considered discriminatory within the meaning of paragraph (4) merely because the contributions or benefits of, or on behalf of, the employees under the plan favor highly compensated employees (as defined in section 414(q) [*26 USCS § 414(q)*]) in the manner permitted under subsection (l).

(D) Integrated defined benefit plan.

(i) In general. A defined benefit plan shall not be considered discriminatory within the meaning of paragraph (4) merely because the plan provides that the employer-derived accrued retirement benefit for any participant under the plan may not exceed the excess (if any) of—

(I)the participant's final pay with the employer, over

(II)the employer-derived retirement benefit created under Federal law attributable to service by the participant with the employer.

For purposes of this clause, the employer-derived retirement benefit created under Federal law shall be treated as accruing ratably over 35 years.

(ii) Final pay. For purposes of this subparagraph, the participant's final pay is the compensation (as defined in section 414(q)(4) [*26 USCS § 414(q)(4)*]) paid to the participant by the employer for any year—

(I)which ends during the 5-year period ending with the year in which the participant separated from service for the employer, and

(II)for which the participant's total compensation from the employer was highest.

(E)2 or more plans treated as single plan. For purposes of determining whether 2 or more plans of an employer satisfy the requirements of paragraph (4) when considered as a single plan—

(i) Contributions. If the amount of contributions on behalf of the employees allowed as a deduction under section 404 [*26 USCS § 404*] for the taxable year with respect to such plans, taken together, bears a uniform relationship to the compensation (within the meaning of section 414(s) [*26 USCS § 414(a)*]) of such employees, the plans shall not be considered discriminatory merely because the rights of employees to, or derived

from, the employer contributions under the separate plans do not become nonforfeitable at the same rate.

(ii) Benefits. If the employees' rights to benefits under the separate plans do not become nonforfeitable at the same rate, but the levels of benefits provided by the separate plans satisfy the requirements of regulations prescribed by the Secretary to take account of the differences in such rates, the plans shall not be considered discriminatory merely because of the difference in such rates.

(F) Social security retirement age. For purposes of testing for discrimination under paragraph (4)—

(i)the social security retirement age (as defined in section 415(b)(8) [*26 USCS § 415(b)(8)*]) shall be treated as a uniform retirement age, and

(ii)subsidized early retirement benefits and joint and survivor annuities shall not be treated as being unavailable to employees on the same terms merely because such benefits or annuities are based in whole or in part on an employee's social security retirement age (as so defined).

(G) Governmental plans. Paragraphs (3) and (4) shall not apply to a governmental plan (within the meaning of section 414(d) [*26 USCS § 414(d)*]) .

(6)A plan shall be considered as meeting the requirements of paragraph (3) during the whole of any taxable year of the plan if on one day in each quarter it satisfied such requirements.

(7)A trust shall not constitute a qualified trust under this section unless the plan of which such trust is a part satisfies the requirements of section 411 [*26 USCS § 411*] (relating to minimum vesting standards).

(8)A trust forming part of a defined benefit plan shall not constitute a qualified trust under this section unless the plan provides that forfeitures must not be applied to increase the benefits any employee would otherwise receive under the plan.

(9) Required distributions.

(A) In general. A trust shall not constitute a qualified trust under this subsection unless the plan provides that the entire interest of each employee—

(i)will be distributed to such employee not later than the required beginning date, or

(ii)will be distributed, beginning not later than the required beginning date, in accordance with regulations, over the life of such employee or over the lives of such employee and a designated beneficiary (or over a period not extending beyond the life expectancy of such employee or the life expectancy of such employee and a designated beneficiary).

(B) Required distribution where employee dies before entire interest is distributed.

(i) Where distributions have begun under subparagraph (A)(ii). A trust shall not constitute a qualified trust under this section unless the plan provides that if—

(I)the distribution of the employee's interest has begun in accordance with subparagraph (A)(ii), and

(II)the employee dies before his entire interest has been distributed to him,

the remaining portion of such interest will be distributed at least as rapidly as under the method of distributions being used under subparagraph (A)(ii) as of the date of his death.

(ii)5-year rule for other cases. A trust shall not constitute a qualified trust under this section unless the plan provides that, if an employee dies before the distribution of the employee's interest has begun in accordance with subparagraph (A)(ii), the entire interest of the employee will be distributed within 5 years after the death of such employee.

(iii) Exception to 5-year rule for certain amounts payable over life of beneficiary. If—

(I)any portion of the employee's interest is payable to (or for the benefit of) a designated beneficiary,

(II)such portion will be distributed (in accordance with regulations) over the life of such designated beneficiary (or over a period not extending beyond the life expectancy of such beneficiary), and

(III)such distributions begin not later than 1 year after the date of the employee's death or such later date as the Secretary may by regulations prescribe,

for purposes of clause (ii), the portion referred to in subclause (I) shall be treated as distributed on the date on which such distributions begin.

(iv) Special rule for surviving spouse of employee. If the designated beneficiary referred to in clause (iii)(I) is the surviving spouse of the employee—

(I)the date on which the distributions are required to begin under clause (iii)(III) shall not be earlier than the date on which the employee would have attained age 72, and

(II)if the surviving spouse dies before the distributions to such spouse begin, this subparagraph shall be applied as if the surviving spouse were the employee.

(C) Required beginning date. For purposes of this paragraph—

(i) In general. The term "required beginning date" means April 1 of the calendar year following the later of—

(I)the calendar year in which the employee attains age 72, or

(II)the calendar year in which the employee retires.

(ii) Exception. Subclause (II) of clause (i) shall not apply—

(I)except as provided in section 409(d) [*26 USCS § 409(d)*], in the case of an employee who is a 5-percent owner (as defined in section 416 [*26 USCS § 416*]) with respect to the plan year ending in the calendar year in which the employee attains age 72, or

(II)for purposes of section 408 (a)(6) or (b)(3) [*26 USCS § 408(a)(6)* or (b)(3)].

(iii) Actuarial adjustment. In the case of an employee to whom clause (i)(II) applies who retires in a calendar year after the calendar year in which the employee attains age 70 ½, the employee's accrued benefit shall be actuarially increased to take into account the period after age 70 ½ in which the employee was not receiving any benefits under the plan.

(iv) Exception for governmental and church plans. Clauses (ii) and (iii) shall not apply in the case of a governmental plan or church plan. For purposes of this clause, the term "church plan" means a plan maintained by a church for church employees, and the term "church" means any church (as defined in section 3121(w)(3)(A) [*26 USCS § 3121(w)(3)(A)*]) or qualified church-controlled organization (as defined in section 3121(w)(3)(B) [*26 USCS § 3121(w)(3)(B)*]).

(D) Life expectancy. For purposes of this paragraph, the life expectancy of an employee and the employee's spouse (other than in the case of a life annuity) may be redetermined but not more frequently than annually.

(E) Definitions and rules relating to designated beneficiaries. For purposes of this paragraph—

(i) Designated beneficiary. The term "designated beneficiary" means any individual designated as a beneficiary by the employee.

(ii) Eligible designated beneficiary. The term "eligible designated beneficiary" means, with respect to any employee, any designated beneficiary who is—

(I)the surviving spouse of the employee,

(II)subject to clause (iii), a child of the employee who has not reached majority (within the meaning of subparagraph (F)),

(III)disabled (within the meaning of section 72(m)(7) [*26 USCS § 72(m)(7)*]),

(IV)a chronically ill individual (within the meaning of section 7702B(c)(2) [*26 USCS § 7702B(c)(2)*], except that the requirements of subparagraph (A)(i) thereof shall only be treated as met if there is a certification that, as of such date, the period of inability described in such subparagraph with respect to the individual is an indefinite one which is reasonably expected to be lengthy in nature), or

(V)an individual not described in any of the preceding subclauses who is not more than 10 years younger than the employee.

The determination of whether a designated beneficiary is an eligible designated beneficiary shall be made as of the date of death of the employee.

(iii)special rule for children. Subject to subparagraph (F), an individual described in clause (ii)(II) shall cease to be an eligible designated beneficiary as of the date the individual reaches majority and any remainder of the portion of the individual's interest to which subparagraph (H)(ii) applies shall be distributed within 10 years after such date.

(F) Treatment of payments to children. Under regulations prescribed by the Secretary, for purposes of this paragraph, any amount paid to a child shall be treated as if it had been paid

to the surviving spouse if such amount will become payable to the surviving spouse upon such child reaching majority (or other designated event permitted under regulations).

(G) Treatment of incidental death benefit distributions. For purposes of this title, any distribution required under the incidental death benefit requirements of this subsection shall be treated as a distribution required under this paragraph.

(H) Special rules for certain defined contribution plans. In the case of a defined contribution plan, if an employee dies before the distribution of the employee's entire interest—

(i) In general. Except in the case of a beneficiary who is not a designated beneficiary, subparagraph (B)(ii)—

(I)shall be applied by substituting "10 years" for "5 years", and

(II)shall apply whether or not distributions of the employee's interests have begun in accordance with subparagraph (A).

(ii) Exception for eligible designated beneficiaries. Subparagraph (B)(iii) shall apply only in the case of an eligible designated beneficiary.

(iii) Rules upon death of eligible designated beneficiary. If an eligible designated beneficiary dies before the portion of the employee's interest to which this subparagraph applies is entirely distributed, the exception under clause (ii) shall not apply to any beneficiary of such eligible designated beneficiary and the remainder of such portion shall be distributed within 10 years after the death of such eligible designated beneficiary.

(iv) Special rule in case of certain trusts for disabled or chronically ill beneficiaries. In the case of an applicable multi-beneficiary trust, if under the terms of the trust—

(I)it is to be divided immediately upon the death of the employee into separate trusts for each beneficiary, or

(II)no individual (other than a eligible designated beneficiary described in subclause (III) or (IV) of subparagraph (E)(ii)) has any right to the employee's interest in the plan until the death of all such eligible designated beneficiaries with respect to the trust,

for purposes of a trust described in subclause (I), clause (ii) shall be applied separately with respect to the portion of the employee's interest that is payable to any eligible designated beneficiary described in subclause (III) or (IV) of subparagraph (E)(ii); and, for purposes of a trust described in subclause (II), subparagraph (B)(iii) shall apply to the distribution of the employee's interest and any beneficiary who is not such an eligible designated beneficiary shall be treated as a beneficiary of the eligible designated beneficiary upon the death of such eligible designated beneficiary.

(v) Applicable multi-beneficiary trust. For purposes of this subparagraph, the term "applicable multi-beneficiary trust" means a trust—

(I)which has more than one beneficiary,

(II)all of the beneficiaries of which are treated as designated beneficiaries for purposes of determining the distribution period pursuant to this paragraph, and

(III)at least one of the beneficiaries of which is an eligible designated beneficiary described in subclause (III) or (IV) of subparagraph (E)(ii).

(vi)application to certain eligible retirement plans. For purposes of applying the provisions of this subparagraph in determining amounts required to be distributed pursuant to this paragraph, all eligible retirement plans (as defined in section 402(c)(8)(B) [*26 USCS § 402(c)(8)(B)*], other than a defined benefit plan described in clause (iv) or (v) thereof or a qualified trust which is a part of a defined benefit plan) shall be treated as a defined contribution plan.

(I) Temporary waiver of minimum required distribution.

(i) In general. The requirements of this paragraph shall not apply for calendar year 2020 to—

(I)a defined contribution plan which is described in this subsection or in section 403(a) or 403(b) [26 USCS § 403(a) or (b)],

(II)a defined contribution plan which is an eligible deferred compensation plan described in section 457(b) [26 USCS § 457(b)] but only if such plan is maintained by an employer described in section 457(e)(1)(A) [*26 USCS § 457(e)(1)(A)*], or

(III)an individual retirement plan.

(ii) Special rule for required beginning dates in 2020. Clause (i) shall apply to any distribution which is required to be made in calendar year 2020 by reason of—

(I)a required beginning date occurring in such calendar year, and

(II)such distribution not having been made before January 1, 2020.

(iii) Special rules regarding waiver period. For purposes of this paragraph—

(I)the required beginning date with respect to any individual shall be determined without regard to this subparagraph for purposes of applying this paragraph for calendar years after 2020, and

(II)if clause (ii) of subparagraph (B) applies, the 5-year period described in such clause shall be determined without regard to calendar year 2020.

(10) Other requirements.

(A) Plans benefiting owner-employees. In the case of any plan which provides contributions or benefits for employees some or all of whom are owner-employees (as defined in subsection (c)(3)), a trust forming part of such plan shall constitute a qualified trust under this section only if the requirements of subsection (d) are also met.

(B) Top-heavy plans.

(i) In general. In the case of any top-heavy plan, a trust forming part of such plan shall constitute a qualified trust under this section only if the requirements of section 416 [*26 USCS § 416*] are met.

(ii) Plans which may become top-heavy. Except to the extent provided in regulations, a trust forming part of a plan (whether or not a top-heavy plan) shall constitute a qualified trust under this section only if such plan contains provisions—

(I)which will take effect if such plan becomes a top-heavy plan, and

(II)which meet the requirements of section 416 [*26 USCS § 416*].

(iii) Exemption for governmental plans. This subparagraph shall not apply to any governmental plan.

(11) Requirement of joint and survivor annuity and preretirement survivor annuity.

(A) In general. In the case of any plan to which this paragraph applies, except as provided in section 417 [*26 USCS § 417*], a trust forming part of such plan shall not constitute a qualified trust under this section unless—

(i)in the case of a vested participant who does not die before the annuity starting date, the accrued benefit payable to such participant is provided in the form of a qualified joint and survivor annuity, and

(ii)in the case of a vested participant who dies before the annuity starting date and who has a surviving spouse, a qualified preretirement survivor annuity is provided to the surviving spouse of such participant.

(B) Plans to which paragraph applies. This paragraph shall apply to—

(i)any defined benefit plan,

(ii)any defined contribution plan which is subject to the funding standards of section 412 [*26 USCS § 412*], and

(iii)any participant under any other defined contribution plan unless—

(I)such plan provides that the participant's nonforfeitable accrued benefit (reduced by any security interest held by the plan by reason of a loan outstanding to such participant) is payable in full, on the death of the participant, to the participant's surviving spouse (or, if there is no surviving spouse or the surviving spouse consents in the manner required under section 417(a)(2) [*26 USCS § 417(a)(2)*], to a designated beneficiary),

(II)such participant does not elect a payment of benefits in the form of a life annuity, and

(III)with respect to such participant, such plan is not a direct or indirect transferee (in a transfer after December 31, 1984) of a plan which is described in clause (i) or (ii) or to which this clause applied with respect to the participant.

Clause (iii)(III) shall apply only with respect to the transferred assets (and income therefrom) if the plan separately accounts for such assets and any income therefrom.

(C) Exception for certain ESOP benefits.

(i) In general. In the case of—

(I)a tax credit employee stock ownership plan (as defined in section 409(a) [*26 USCS § 409(a)*]), or

(II)an employee stock ownership plan (as defined in section 4975(e)(7) [*26 USCS § 4975(e)(7)*]),

subparagraph (A) shall not apply to that portion of the employee's accrued benefit to which the requirements of section 409(h) [*26 USCS § 409(h)*] apply.

(ii) Nonforfeitable benefit must be paid in full, etc. In the case of any participant, clause (i) shall apply only if the requirements of subclauses (I), (II), and (III) of subparagraph (B)(iii) are met with respect to such participant.

(D) Special rule where participant and spouse married less than 1 year. A plan shall not be treated as failing to meet the requirements of subparagraphs (B)(iii) or (C) merely because the plan provides that benefits will not be payable to the surviving spouse of the participant unless the participant and such spouse had been married throughout the 1-year period ending on the earlier of the participant's annuity starting date or the date of the participant's death.

(E) Exception for plans described in section 404(c) [*26 USCS § 404(c)*]. This paragraph shall not apply to a plan which the Secretary has determined is a plan described in section 404(c) [*26 USCS § 404(c)*] (or a continuation thereof) in which participation is substantially limited to individuals who, before January 1, 1976, ceased employment covered by the plan.

(F) Cross reference. For—

(i)provisions under which participants may elect to waive the requirements of this paragraph, and

(ii)other definitions and special rules for purposes of this paragraph,

see section 417 [*26 USCS § 417*].

(12)A trust shall not constitute a qualified trust under this section unless the plan of which such trust is a part provides that in the case of any merger or consolidation with, or transfer of assets or liabilities to, any other plan after September 2, 1974, each participant in the plan would (if the plan then terminated) receive a benefit immediately after the merger, consolidation, or transfer which is equal to or greater than the benefit he would have been entitled to receive immediately before the merger, consolidation, or transfer (if the plan had then terminated). The preceding sentence does not apply to any multiemployer plan with respect to any transaction to the extent that participants either before or after the transaction are covered under a multiemployer plan to which title IV of the Employee Retirement Income Security Act of 1974 [*29 USCS §§ 1301* et seq.] applies.

(13) Assignment and alienation.

(A) In general. A trust shall not constitute a qualified trust under this section unless the plan of which such trust is a part provides that benefits provided under the plan may not be assigned or alienated. For purposes of the preceding sentence, there shall not be taken into account any voluntary and revocable assignment of not to exceed 10 percent of any benefit payment made by any participant who is receiving benefits under the plan unless the

assignment or alienation is made for purposes of defraying plan administration costs. For purposes of this paragraph a loan made to a participant or beneficiary shall not be treated as an assignment or alienation if such loan is secured by the participant's accrued nonforfeitable benefit and is exempt from the tax imposed by section 4975 [*26 USCS § 4975*] (relating to tax on prohibited transactions) by reason of section 4975(d)(1) [*26 USCS § 4975(d)(1)*]. This paragraph shall take effect on January 1, 1976 and shall not apply to assignments which were irrevocable on September 2, 1974.

(B) Special rules for domestic relations orders. Subparagraph (A) shall apply to the creation, assignment, or recognition of a right to any benefit payable with respect to a participant pursuant to a domestic relations order, except that subparagraph (A) shall not apply if the order is determined to be a qualified domestic relations order.

(C) Special rule for certain judgments and settlements. Subparagraph (A) shall not apply to any offset of a participant's benefits provided under a plan against an amount that the participant is ordered or required to pay to the plan if—

(i)the order or requirement to pay arises—

(I)under a judgment of conviction for a crime involving such plan,

(II)under a civil judgment (including a consent order or decree) entered by a court in an action brought in connection with a violation (or alleged violation) of part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 [*29 USCS §§ 1101* et seq.], or

(III)pursuant to a settlement agreement between the Secretary of Labor and the participant, or a settlement agreement between the Pension Benefit Guaranty Corporation and the participant, in connection with a violation (or alleged violation) of part 4 of such subtitle [*29 USCS §§ 1101* et seq.] by a fiduciary or any other person,

(ii)the judgment, order, decree, or settlement agreement expressly provides for the offset of all or part of the amount ordered or required to be paid to the plan against the participant's benefits provided under the plan, and

(iii)in a case in which the survivor annuity requirements of section 401(a)(11) [*26 USCS § 401(a)(11)*] apply with respect to distributions from the plan to the participant, if the participant has a spouse at the time at which the offset is to be made—

(I)either such spouse has consented in writing to such offset and such consent is witnessed by a notary public or representative of the plan (or it is established to the satisfaction of a plan representative that such consent may not be obtained by reason of circumstances described in section 417(a)(2)(B) [*26 USCS § 417(a)(2)(B)*]), or an election to waive the right of the spouse to either a qualified joint and survivor annuity or a qualified preretirement survivor annuity is in effect in accordance with the requirements of section 417(a) [*26 USCS § 417(a)*],

(II)such spouse is ordered or required in such judgment, order, decree, or settlement to pay an amount to the plan in connection with a violation of part 4 of such subtitle [*29 USCS §§ 1101* et seq.], or

(III)in such judgment, order, decree, or settlement, such spouse retains the right to receive the survivor annuity under a qualified joint and survivor annuity provided pursuant to section 401(a)(11)(A)(i) [*26 USCS § 401(a)(11)(A)(i)*] and under a qualified preretirement survivor annuity provided pursuant to section 401(a)(11)(A)(ii) [*26 USCS § 401(a)(11)(A)(ii)*], determined in accordance with subparagraph (D).

A plan shall not be treated as failing to meet the requirements of this subsection, subsection (k), section 403(b) [*26 USCS § 403(b)*], or section 409(d) [*26 USCS § 409(d)*] solely by reason of an offset described in this subparagraph.

(D) Survivor annuity.

(i) In general. The survivor annuity described in subparagraph (C)(iii)(III) shall be determined as if—

(I)the participant terminated employment on the date of the offset,

(II)there was no offset,

(III)the plan permitted commencement of benefits only on or after normal retirement age,

(IV)the plan provided only the minimum-required qualified joint and survivor annuity, and

(V)the amount of the qualified preretirement survivor annuity under the plan is equal to the amount of the survivor annuity payable under the minimum-required qualified joint and survivor annuity.

(ii) Definition. For purposes of this subparagraph, the term "minimum-required qualified joint and survivor annuity" means the qualified joint and survivor annuity which is the actuarial equivalent of the participant's accrued benefit (within the meaning of section 411(a)(7) [*26 USCS § 411(a)(7)*]) and under which the survivor annuity is 50 percent of the amount of the annuity which is payable during the joint lives of the participant and the spouse.

(14)A trust shall not constitute a qualified trust under this section unless the plan of which such trust is a part provides that, unless the participant otherwise elects, the payment of benefits under the plan to the participant will begin not later than the 60th day after the latest of the close of the plan year in which—

(A)the date on which the participant attains the earlier of age 65 or the normal retirement age specified under the plan,

(B)occurs the 10th anniversary of the year in which the participant commenced participation in the plan, or

(C)the participant terminates his service with the employer.

In the case of a plan which provides for the payment of an early retirement benefit, a trust forming a part of such plan shall not constitute a qualified trust under this section unless a participant who satisfied the service requirements for such early retirement benefit, but separated from the service (with any nonforfeitable right to an accrued benefit) before

satisfying the age requirement for such early retirement benefit, is entitled upon satisfaction of such age requirement to receive a benefit not less than the benefit to which he would be entitled at the normal retirement age, actuarially, reduced under regulations prescribed by the Secretary.

(15)A trust shall not constitute a qualified trust under this section unless under the plan of which such trust is a part—

(A)in the case of a participant or beneficiary who is receiving benefits under such plan, or

(B)in the case of a participant who is separated from the service and who has nonforfeitable rights to benefits,

such benefits are not decreased by reason of any increase in the benefit levels payable under title II of the Social Security Act [*42 USCS §§ 401* et seq.] or any increase in the wage base under such title II, if such increase takes place after September 2, 1974, or (if later) the earlier of the date of first receipt of such benefits or the date of such separation, as the case may be.

(16)A trust shall not constitute a qualified trust under this section if the plan of which such trust is a part provides for benefits or contributions which exceed the limitations of section 415 [*26 USCS § 415*].

(17) Compensation limit.

(A) In general. A trust shall not constitute a qualified trust under this section unless, under the plan of which such trust is a part, the annual compensation of each employee taken into account under the plan for any year does not exceed $200,000.

(B) Cost-of-living adjustment. The Secretary shall adjust annually the $200,000 amount in subparagraph (A) for increases in the cost-of-living at the same time and in the same manner as adjustments under section 415(d) [*26 USCS § 415(d)*]; except that the base period shall be the calendar quarter beginning July 1, 2001, and any increase which is not a multiple of $5,000 shall be rounded to the next lowest multiple of $5,000.

(18) [Repealed.]

(19)A trust shall not constitute a qualified trust under this section if under the plan of which such trust is a part any part of a participant's accrued benefit derived from employer contributions (whether or not otherwise nonforfeitable), is forfeitable solely because of withdrawal by such participant of any amount attributable to the benefit derived from contributions made by such participant. The preceding sentence shall not apply to the accrued benefit of any participant unless, at the time of such withdrawal, such participant has a nonforfeitable right to at least 50 percent of such accrued benefit (as determined under section 411 [*26 USCS § 411*]). The first sentence of this paragraph shall not apply to the extent that an accrued benefit is permitted to be forfeited in accordance with section 411(a)(3)(D)(iii) [*26 USCS § 411(a)(3)(D)(iii)*] (relating to proportional forfeitures of benefits accrued before September 2, 1974, in the event of withdrawal of certain mandatory contributions).

(20)A trust forming part of a pension plan shall not be treated as failing to constitute a qualified trust under this section merely because the pension plan of which such trust is a part makes 1 or more distributions within 1 taxable year to a distributee on account of a termination of the plan of which the trust is a part, or in the case of a profit-sharing or stock bonus plan, a

complete discontinuance of contributions under such plan. This paragraph shall not apply to a defined benefit plan unless the employer maintaining such plan files a notice with the Pension Benefit Guaranty Corporation (at the time and in the manner prescribed by the Pension Benefit Guaranty Corporation) notifying the Corporation of such payment or distribution and the Corporation has approved such payment or distribution or, within 90 days after the date on which such notice was filed, has failed to disapprove such payment or distribution. For purposes of this paragraph, rules similar to the rules of section 402(a)(6)(B) [*26 USCS § 402(a)(6)(B)*] (as in effect before its repeal by section 521 of the Unemployment Compensation Amendments of 1992) shall apply.

(21) [Repealed.]

(22) If a defined contribution plan (other than a profit-sharing plan)—

(A)is established by an employer whose stock is not readily tradable on an established market, and

(B)after acquiring securities of the employer, more than 10 percent of the total assets of the plan are securities of the employer,

any trust forming part of such plan shall not constitute a qualified trust under this section unless the plan meets the requirements of subsection (e) of section 409 [*26 USCS § 409*]. The requirements of subsection (e) of section 409 [*26 USCS § 409*] shall not apply to any employees of an employer who are participants in any defined contribution plan established and maintained by such employer if the stock of such employer is not readily tradable on an established market and the trade or business of such employer consists of publishing on a regular basis a newspaper for general circulation. For purposes of the preceding sentence, subsections (b), (c), (m), and (o) of section 414 [*26 USCS § 414*] shall not apply except for determining whether stock of the employer is not readily tradable on an established market.

(23)A stock bonus plan shall not be treated as meeting the requirements of this section unless such plan meets the requirements of subsections (h) and (o) of section 409 [*26 USCS § 409*], except that in applying section 409(h) [*26 USCS § 409(h)*] for purposes of this paragraph, the term “employer securities” shall include any securities of the employer held by the plan.

(24) Any group trust which otherwise meets the requirements of this section shall not be treated as not meeting such requirements on account of the participation or inclusion in such trust of the moneys of any plan or governmental unit described in section 818(a)(6) [*26 USCS § 818(a)(6)*].

(25) Requirement that actuarial assumptions be specified. A defined benefit plan shall not be treated as providing definitely determinable benefits unless, whenever the amount of any benefit is to be determined on the basis of actuarial assumptions, such assumptions are specified in the plan in a way which precludes employer discretion.

(26) Additional participation requirements.

(A) In general. In the case of a trust which is a part of a defined benefit plan, such trust shall not constitute a qualified trust under this subsection unless on each day of the plan year such trust benefits at least the lesser of—

(i)50 employees of the employer, or

(ii)the greater of—

(I)40 percent of all employees of the employer, or

(II)2 employees (or if there is only 1 employee, such employee).

(B) Treatment of excludable employees.

(i) In general. A plan may exclude from consideration under this paragraph employees described in paragraphs (3) and (4)(A) of section 410(b) [*26 USCS § 410(b)*].

(ii) Separate application for certain excludable employees. If employees described in section 410(b)(4)(B) [*26 USCS § 410(b)(4)(B)*] are covered under a plan which meets the requirements of subparagraph (A) separately with respect to such employees, such employees may be excluded from consideration in determining whether any plan of the employer meets such requirements if—

(I)the benefits for such employees are provided under the same plan as benefits for other employees,

(II)the benefits provided to such employees are not greater than comparable benefits provided to other employees under the plan, and

(III)no highly compensated employee (within the meaning of section 414(q) [*26 USCS § 414(q)*]) is included in the group of such employees for more than 1 year.

(C) Special rule for collective bargaining units. Except to the extent provided in regulations, a plan covering only employees described in section 410(b)(3)(A) [*26 USCS § 410(b)(3)(A)*] may exclude from consideration any employees who are not included in the unit or units in which the covered employees are included.

(D) Paragraph not to apply to multiemployer plans. Except to the extent provided in regulations, this paragraph shall not apply to employees in a multiemployer plan (within the meaning of section 414(f) [*26 USCS § 414(f)*]) who are covered by collective bargaining agreements.

(E) Special rule for certain dispositions or acquisitions. Rules similar to the rules of section 410(b)(6)(C) [*26 USCS § 410(b)(6)(C)*] shall apply for purposes of this paragraph.

(F) Separate lines of business. At the election of the employer and with the consent of the Secretary, this paragraph may be applied separately with respect to each separate line of business of the employer. For purposes of this paragraph, the term “separate line of business” has the meaning given such term by section 414(r) [*26 USCS § 414(r)*] (without regard to paragraph (2)(A) or (7) thereof).

(G) Exception for governmental plans. This paragraph shall not apply to a governmental plan (within the meaning of section 414(d) [*26 USCS § 414(d)*]).

(H) Regulations. The Secretary may by regulation provide that any separate benefit structure, any separate trust, or any other separate arrangement is to be treated as a separate plan for purposes of applying this paragraph.

(I) Protected participants.

(i) In general. A plan shall be deemed to satisfy the requirements of subparagraph (A) if—

(I)the plan is amended—

(aa)to cease all benefit accruals, or

(bb)to provide future benefit accruals only to a closed class of participants,

(II)the plan satisfies subparagraph (A) (without regard to this subparagraph) as of the effective date of the amendment, and

(III)the amendment was adopted before April 5, 2017, or the plan is described in clause (ii).

(ii) Plans described. A plan is described in this clause if the plan would be described in subsection (o)(1)(C), as applied for purposes of subsection (o)(1)(B)(iii)(IV) and by treating the effective date of the amendment as the date the class was closed for purposes of subsection (o)(1)(C).

(iii) Special rules. For purposes of clause (i)(II), in applying section 410(b)(6)(C) [*26 USCS § 410(b)(6)(C)*], the amendments described in clause (i) shall not be treated as a significant change in coverage under section 410(b)(6)(C)(i)(II) [*26 USCS § 410(b)(6)(C)(i)(II)*].

(iv) Spun-off plans. For purposes of this subparagraph, if a portion of a plan described in clause (i) is spun off to another employer, the treatment under clause (i) of the spun-off plan shall continue with respect to the other employer.

(27) Determinations as to profit-sharing plans.

(A) Contributions need not be based on profits. The determination of whether the plan under which any contributions are made is a profit-sharing plan shall be made without regard to current or accumulated profits of the employer and without regard to whether the employer is a tax-exempt organization.

(B) Plan must designate type. In the case of a plan which is intended to be a money purchase pension plan or a profit-sharing plan, a trust forming part of such plan shall not constitute a qualified trust under this subsection unless the plan designates such intent at such time and in such manner as the Secretary may prescribe.

(28) Additional requirements relating to employee stock ownership plans.

(A) In general. In the case of a trust which is part of an employee stock ownership plan (within the meaning of section 4975(e)(7) [*26 USCS § 4975(e)(7)*]) or a plan which meets the requirements of section 409(a) [*26 USCS § 409(a)*], such trust shall not constitute a qualified trust under this section unless such plan meets the requirements of subparagraphs (B) and (C).

(B) Diversification of investments.

(i) In general. A plan meets the requirements of this subparagraph if each qualified participant in the plan may elect within 90 days after the close of each plan year in the qualified election period to direct the plan as to the investment of at least 25 percent of the participant's account in the plan (to the extent such portion exceeds the amount to

which a prior election under this subparagraph applies). In the case of the election year in which the participant can make his last election, the preceding sentence shall be applied by substituting "50 percent" for "25 percent".

(ii) Method of meeting requirements. A plan shall be treated as meeting the requirements of clause (i) if—

(I)the portion of the participant's account covered by the election under clause (i) is distributed within 90 days after the period during which the election may be made, or

(II)the plan offers at least 3 investment options (not inconsistent with regulations prescribed by the Secretary) to each participant making an election under clause (i) and within 90 days after the period during which the election may be made, the plan invests the portion of the participant's account covered by the election in accordance with such election.

(iii) Qualified participant. For purposes of this subparagraph, the term "qualified participant" means any employee who has completed at least 10 years of participation under the plan and has attained age 55.

(iv) Qualified election period. For purposes of this subparagraph, the term "qualified election period" means the 6-plan-year period beginning with the later of—

(I)the 1st plan year in which the individual first became a qualified participant, or

(II)the 1st plan year beginning after December 31, 1986.

For purposes of the preceding sentence, an employer may elect to treat an individual first becoming a qualified participant in the 1st plan year beginning in 1987 as having become a participant in the 1st plan year beginning in 1988.

(v) Exception. This subparagraph shall not apply to an applicable defined contribution plan (as defined in paragraph (35)(E)).

(C) Use of independent appraiser. A plan meets the requirements of this subparagraph if all valuations of employer securities which are not readily tradable on an established securities market with respect to activities carried on by the plan are by an independent appraiser. For purposes of the preceding sentence, the term "independent appraiser" means any appraiser meeting requirements similar to the requirements of the regulations prescribed under section 170(a)(1) [*26 USCS § 170(a)(1)*].

(29) Benefit limitations. In the case of a defined benefit plan (other than a multiemployer plan or a CSEC plan) to which the requirements of section 412 [*26 USCS § 412*] apply, the trust of which the plan is a part shall not constitute a qualified trust under this subsection unless the plan meets the requirements of section 436 [*26 USCS § 436*].

(30) Limitations on elective deferrals. In the case of a trust which is part of a plan under which elective deferrals (within the meaning of section 402(g)(3) [*26 USCS § 402(g)(3)*]) may be made with respect to any individual during a calendar year, such trust shall not constitute a qualified trust under this subsection unless the plan provides that the amount of such deferrals under such plan and all other plans, contracts, or arrangements of an employer maintaining

such plan may not exceed the amount of the limitation in effect under section 402(g)(1)(A) [*26 USCS § 402(g)(1)(A)*] for taxable years beginning in such calendar year.

(31) Direct transfer of eligible rollover distributions.

(A) In general. A trust shall not constitute a qualified trust under this section unless the plan of which such trust is a part provides that if the distributee of any eligible rollover distribution—

(i)elects to have such distribution paid directly to an eligible retirement plan, and

(ii)specifies the eligible requirement plan to which such distribution is to be paid (in such form and at such time as the plan administrator may prescribe),

such distribution shall be made in the form of a direct trustee-to-trustee transfer to the eligible retirement plan so specified.

(B) Certain mandatory distributions.

(i) In general. In case of a trust which is part of an eligible plan, such trust shall not constitute a qualified trust under this section unless the plan of which such trust is a part provides that if—

(I)a distribution described in clause (ii) in excess of $1,000 is made, and

(II)the distributee does not make an election under subparagraph (A) and does not elect to receive the distribution directly,

the plan administrator shall make such transfer to an individual retirement plan of a designated trustee or issuer and shall notify the distributee in writing (either separately or as part of the notice under section 402(f) [*26 USCS § 402(f)*]) that the distribution may be transferred to another individual retirement plan.

(ii) Eligible plan. For purposes of clause (i), the term "eligible plan" means a plan which provides that any nonforfeitable accrued benefit for which the present value (as determined under section 411(a)(11) [*26 USCS § 411(a)(11)*]) does not exceed $5,000 shall be immediately distributed to the participant.

(C) Limitation. Subparagraphs (A) and (B) shall apply only to the extent that the eligible rollover distribution would be includible in gross income if not transferred as provided in subparagraph (A) (determined without regard to sections 402(c), 403(a)(4), 403(b)(8), and 457(e)(16) [*26 USCS §§ 402(c)*, *403(a)(4)*, *403(b)(8)*, and *457(e)(16)*]). The preceding sentence shall not apply to such distribution if the plan to which such distribution is transferred—

(i)is a qualified trust which is part of a plan which is a defined contribution plan and agrees to separately account for amounts so transferred, including separately accounting for the portion of such distribution which is includible in gross income and the portion of such distribution which is not so includible, or

(ii)is an eligible retirement plan described in clause (i) or (ii) of section 402(c)(8)(B) [*26 USCS § 402(c)(8)(B)*].

(D) Eligible rollover distribution. For purposes of this paragraph, the term "eligible rollover distribution" has the meaning given such term by section 402(f)(2)(A) [*26 USCS § 402(f)(2)(A)*].

(E) Eligible retirement plan. For purposes of this paragraph, the term "eligible retirement plan" has the meaning given such term by section 402(c)(8)(B) [*26 USCS § 402(c)(8)(B)*], except that a qualified trust shall be considered an eligible retirement plan only if it is a defined contribution plan, the terms of which permit the acceptance of rollover distributions.

(32) Treatment of failure to make certain payments if plan has liquidity shortfall.

(A) In general. A trust forming part of a pension plan to which section 430(j)(4) or 433(f)(5) [*26 USCS § 430(j)(4)* or *§ 433(f)(5)*] applies shall not be treated as failing to constitute a qualified trust under this section merely because such plan ceases to make any payment described in subparagraph (B) during any period that such plan has a liquidity shortfall (as defined in section 430(j)(4) or 433(f)(5) [*26 USCS § 430(j)(4)* or *§ 433(f)(5)*]).

(B) Payments described. A payment is described in this subparagraph if such payment is—

(i)any payment, in excess of the monthly amount paid under a single life annuity (plus any social security supplements described in the last sentence of section 411(a)(9) [*26 USCS § 411(a)(9)*]), to a participant or beneficiary whose annuity starting date (as defined in section 417(f)(2) [*26 USCS § 417(f)(2)*]) occurs during the period referred to in subparagraph (A),

(ii)any payment for the purchase of an irrevocable commitment from an insurer to pay benefits, and

(iii)any other payment specified by the Secretary by regulations.

(C) Period of shortfall. For purposes of this paragraph, a plan has a liquidity shortfall during the period that there is an underpayment of an installment under section 430(j)(3) or 433(f) [*26 USCS § 430(j)(3)* or *§ 433(f)*] by reason of section 430(j)(4)(A) or 433(f)(5) [*26 USCS § 430(j)(4)(A)* or *§ 433(f)(5)*], respectively.

(33) Prohibition on benefit increases while sponsor is in bankruptcy.

(A) In general. A trust which is part of a plan to which this paragraph applies shall not constitute a qualified trust under this section if an amendment to such plan is adopted while the employer is a debtor in a case under title 11, United States Code, or similar Federal or State law, if such amendment increases liabilities of the plan by reason of—

(i)any increase in benefits,

(ii)any change in the accrual of benefits, or

(iii)any change in the rate at which benefits become nonforfeitable under the plan,

with respect to employees of the debtor, and such amendment is effective prior to the effective date of such employer's plan of reorganization.

(B) Exceptions. This paragraph shall not apply to any plan amendment if—

(i)the plan, were such amendment to take effect, would have a funding target attainment percentage (as defined in section 430(d)(2)) [*26 USCS § 430(d)(2)*]) of 100 percent or more,

(ii)the Secretary determines that such amendment is reasonable and provides for only de minimis increases in the liabilities of the plan with respect to employees of the debtor,

(iii)such amendment only repeals an amendment described in section 412(d)(2) [*26 USCS § 412(d)(2)*], or

(iv)such amendment is required as a condition of qualification under this part [*26 USCS §§ 401* et seq.].

(C) Plans to which this paragraph applies. This paragraph shall apply only to plans (other than multiemployer plans or CSEC plans) covered under section 4021 of the Employee Retirement Income Security Act of 1974 [*29 USCS § 1321*].

(D) Employer. For purposes of this paragraph, the term "employer" means the employer referred to in section 412(b)(1) [*26 USCS § 412(b)(1)*], without regard to section 412(b)(2) [*26 USCS § 412(b)(2)*].

(34) Benefits of missing participants on plan termination. In the case of a plan covered by title IV of the Employee Retirement Income Security Act of 1974 [*29 USCS §§ 1301* et seq.], a trust forming part of such plan shall not be treated as failing to constitute a qualified trust under this section merely because the pension plan of which such trust is a part, upon its termination, transfers benefits of missing participants to the Pension Benefit Guaranty Corporation in accordance with section 4050 of such Act [*29 USCS § 1350*].

(35) Diversification requirements for certain defined contribution plans.

(A) In general. A trust which is part of an applicable defined contribution plan shall not be treated as a qualified trust unless the plan meets the diversification requirements of subparagraphs (B), (C), and (D).

(B) Employee contributions and elective deferrals invested in employer securities. In the case of the portion of an applicable individual's account attributable to employee contributions and elective deferrals which is invested in employer securities, a plan meets the requirements of this subparagraph if the applicable individual may elect to direct the plan to divest any such securities and to reinvest an equivalent amount in other investment options meeting the requirements of subparagraph (D).

(C) Employer contributions invested in employer securities. In the case of the portion of the account attributable to employer contributions other than elective deferrals which is invested in employer securities, a plan meets the requirements of this subparagraph if each applicable individual who—

(i)is a participant who has completed at least 3 years of service, or

(ii)is a beneficiary of a participant described in clause (i) or of a deceased participant,

may elect to direct the plan to divest any such securities and to reinvest an equivalent amount in other investment options meeting the requirements of subparagraph (D).

(D) Investment options.

(i) In general. The requirements of this subparagraph are met if the plan offers not less than 3 investment options, other than employer securities, to which an applicable individual may direct the proceeds from the divestment of employer securities pursuant to this paragraph, each of which is diversified and has materially different risk and return characteristics.

(ii) Treatment of certain restrictions and conditions.

(I) Time for making investment choices. A plan shall not be treated as failing to meet the requirements of this subparagraph merely because the plan limits the time for divestment and reinvestment to periodic, reasonable opportunities occurring no less frequently than quarterly.

(II) Certain restrictions and conditions not allowed. Except as provided in regulations, a plan shall not meet the requirements of this subparagraph if the plan imposes restrictions or conditions with respect to the investment of employer securities which are not imposed on the investment of other assets of the plan. This subclause shall not apply to any restrictions or conditions imposed by reason of the application of securities laws.

(E) Applicable defined contribution plan. For purposes of this paragraph—

(i) In general. The term "applicable defined contribution plan" means any defined contribution plan which holds any publicly traded employer securities.

(ii) Exception for certain ESOPs. Such term does not include an employee stock ownership plan if—

(I)there are no contributions to such plan (or earnings thereunder) which are held within such plan and are subject to subsection (k) or (m), and

(II)such plan is a separate plan for purposes of section 414(l) [*26 USCS § 414(l)*] with respect to any other defined benefit plan or defined contribution plan maintained by the same employer or employers.

(iii) Exception for one participant plans. Such term does not include a one-participant retirement plan.

(iv) One-participant retirement plan. For purposes of clause (iii), the term "one-participant retirement plan" means a retirement plan that on the first day of the plan year—

(I)covered only one individual (or the individual and the individual's spouse) and the individual (or the individual and the individual's spouse) owned 100 percent of the plan sponsor (whether or not incorporated), or

(II)covered only one or more partners (or partners and their spouses) in the plan sponsor.

(F) Certain plans treated as holding publicly traded employer securities.

(i) In general. Except as provided in regulations or in clause (ii), a plan holding employer securities which are not publicly traded employer securities shall be treated

as holding publicly traded employer securities if any employer corporation, or any member of a controlled group of corporations which includes such employer corporation, has issued a class of stock which is a publicly traded employer security.

(ii) Exception for certain controlled groups with publicly traded securities. Clause (i) shall not apply to a plan if—

(I)no employer corporation, or parent corporation of an employer corporation, has issued any publicly traded employer security, and

(II)no employer corporation, or parent corporation of an employer corporation, has issued any special class of stock which grants particular rights to, or bears particular risks for, the holder or issuer with respect to any corporation described in clause (i) which has issued any publicly traded employer security.

(iii) Definitions. For purposes of this subparagraph, the term—

(I)"controlled group of corporations" has the meaning given such term by section 1563(a) [*26 USCS § 1563(a)*], except that "50 percent" shall be substituted for "80 percent" each place it appears,

(II)"employer corporation" means a corporation which is an employer maintaining the plan, and

(III)"parent corporation" has the meaning given such term by section 424(e) [*26 USCS § 424(e)*].

(G) Other definitions. For purposes of this paragraph—

(i) Applicable individual. The term "applicable individual" means—

(I)any participant in the plan, and

(II)any beneficiary who has an account under the plan with respect to which the beneficiary is entitled to exercise the rights of a participant.

(ii) Elective deferral. The term "elective deferral" means an employer contribution described in section 402(g)(3)(A) [*26 USCS § 402(g)(3)(A)*].

(iii) Employer security. The term "employer security" has the meaning given such term by section 407(d)(1) of the Employee Retirement Income Security Act of 1974 [*29 USCS § 1107(d)(1)*].

(iv) Employee stock ownership plan. The term "employee stock ownership plan" has the meaning given such term by section 4975(e)(7) [*26 USCS § 4975(e)(7)*].

(v) Publicly traded employer securities. The term "publicly traded employer securities" means employer securities which are readily tradable on an established securities market.

(vi) Year of service. The term "year of service" has the meaning given such term by section 411(a)(5) [*26 USCS § 411(a)(5)*].

(H) Transition rule for securities attributable to employer contributions.

(i) Rules phased in over 3 years.

(I) In general. In the case of the portion of an account to which subparagraph (C) applies and which consists of employer securities acquired in a plan year beginning before January 1, 2007, subparagraph (C) shall only apply to the applicable percentage of such securities. This subparagraph shall be applied separately with respect to each class of securities.

(II) Exception for certain participants aged 55 or over. Subclause (I) shall not apply to an applicable individual who is a participant who has attained age 55 and completed at least 3 years of service before the first plan year beginning after December 31, 2005.

(ii) Applicable percentage. For purposes of clause (i), the applicable percentage shall be determined as follows:

Plan year to which subparagraph (C) applies:	The applicable percentage is:
1st	33
2d	66
3d and following	100.

(36) Distributions during working retirement. A trust forming part of a pension plan shall not be treated as failing to constitute a qualified trust under this section solely because the plan provides that a distribution may be made from such trust to an employee who has attained age 59 ½ and who is not separated from employment at the time of such distribution.

(37) Death benefits under USERRA-qualified active military service. A trust shall not constitute a qualified trust unless the plan provides that, in the case of a participant who dies while performing qualified military service (as defined in section 414(u) [*26 USCS § 414(u)*]), the survivors of the participant are entitled to any additional benefits (other than benefit accruals relating to the period of qualified military service) provided under the plan had the participant resumed and then terminated employment on account of death.

Paragraphs (11), (12), (13), (14), (15), (19), and (20) shall apply only in the case of a plan to which section 411 [*26 USCS § 411*] (relating to minimum vesting standards) applies without regard to subsection (e)(2) of such section.

(38) Portability of lifetime income.

(A) In general. Except as may be otherwise provided by regulations, a trust forming part of a defined contribution plan shall not be treated as failing to constitute a qualified trust under this section solely by reason of allowing—

(i)qualified distributions of a lifetime income investment, or

(ii)distributions of a lifetime income investment in the form of a qualified plan distribution annuity contract,

on or after the date that is 90 days prior to the date on which such lifetime income investment is no longer authorized to be held as an investment option under the plan.

(B) Definitions. For purposes of this subsection—

(i)the term "qualified distribution" means a direct trustee-to-trustee transfer described in paragraph (31)(A) to an eligible retirement plan (as defined in section 402(c)(8)(B) [*26 USCS § 402(c)(8)(b)*]),

(ii)the term "lifetime income investment" means an investment option which is designed to provide an employee with election rights—

(I)which are not uniformly available with respect to other investment options under the plan, and

(II)which are to a lifetime income feature available through a contract or other arrangement offered under the plan (or under another eligible retirement plan (as so defined), if paid by means of a direct trustee-to-trustee transfer described in paragraph (31)(A) to such other eligible retirement plan),

(iii)the term "lifetime income feature" means—

(I)a feature which guarantees a minimum level of income annually (or more frequently) for at least the remainder of the life of the employee or the joint lives of the employee and the employee's designated beneficiary, or

(II)an annuity payable on behalf of the employee under which payments are made in substantially equal periodic payments (not less frequently than annually) over the life of the employee or the joint lives of the employee and the employee's designated beneficiary, and

(iv)the term "qualified plan distribution annuity contract" means an annuity contract purchased for a participant and distributed to the participant by a plan or contract described in subparagraph (B) of section 402(c)(8) [*26 USCS § 402(c)(8)*] (without regard to clauses (i) and (ii) thereof).

(b) Plan amendments.

(1) Certain retroactive changes in plan. A stock bonus, pension, profit-sharing, or annuity plan shall be considered as satisfying the requirements of subsection (a) for the period beginning with the date on which it was put into effect, or for the period beginning with the earlier of the date on which there was adopted or put into effect any amendment which caused the plan to fail to satisfy such requirements, and ending with the time prescribed by law for filing the return of the employer for his taxable year in which such plan or amendment was adopted (including extensions thereof) or such later time as the Secretary may designate, if all provisions of the plan which are necessary to satisfy such requirements are in effect by the end of such period and have been made effective for all purposes for the whole of such period.

(2) Adoption of plan. If an employer adopts a stock bonus, pension, profit-sharing, or annuity plan after the close of a taxable year but before the time prescribed by law for filing the return of the employer for the taxable year (including extensions thereof), the employer may elect to treat the plan as having been adopted as of the last day of the taxable year.

(c) Definitions and rules relating to self-employed individuals and owner-employees. For purposes of this section—

(1) Self-employed individual treated as employee.

(A) In general. The term "employee" includes, for any taxable year, an individual who is a self-employed individual for such taxable year.

(B) Self-employed individual. The term "self-employed individual" means, with respect to any taxable year, an individual who has earned income (as defined in paragraph (2)) for such taxable year. To the extent provided in regulations prescribed by the Secretary, such term also includes, for any taxable year—

(i)an individual who would be a self-employed individual within the meaning of the preceding sentence but for the fact that the trade or business carried on by such individual did not have net profits for the taxable year, and

(ii)an individual who has been a self-employed individual within the meaning of the preceding sentence for any prior taxable year.

(2) Earned income.

(A) In general. The term "earned income" means the net earnings from self-employment (as defined in section 1402(a) [*26 USCS § 1402(a)*]), but such net earnings shall be determined—

(i)only with respect to a trade or business in which personal services of the taxpayer are a material income-producing factor,

(ii)without regard to paragraphs (4) and (5) of section 1402(c) [*26 USCS § 1402(c)*],

(iii)in the case of any individual who is treated as an employee under subparagraph (A), (C), or (D) of section 3121(d)(3) [*26 USCS § 3121(d)(3)*], without regard to section 1402(c)(2) [*26 USCS § 1402(c)(2)*],

(iv)without regard to items which are not included in gross income for purposes of this chapter [*26 USCS §§ 1* et seq.], and the deductions properly allocable to or chargeable against such items,

(v)with regard to the deductions allowed by section 404 [*26 USCS § 404*] to the taxpayer, and

(vi)with regard to the deduction allowed to the taxpayer by section 164(f) [*26 USCS § 164(f)*].

For purposes of this subparagraph, section 1402 [*26 USCS § 1402*], as in effect for a taxable year ending on December 31, 1962, shall be treated as having been in effect for all taxable years ending before such date. For purposes of this part [*26 USCS §§ 401* et seq.] only (other than sections 419 and 419A [*26 USCS §§ 419* and *419A*]), this subparagraph shall be applied as if the term "trade or business" for purposes of section 1402 [*26 USCS § 1402*] included service described in section 1402(c)(6) [*26 USCS § 1402(c)(6)*].

(B)[Repealed.]

(C) Income from disposition of certain property. For purposes of this section, the term "earned income" includes gains (other than any gain which is treated under any provision of this chapter [*26 USCS §§ 1* et seq.] as gain from the sale or exchange of a capital asset) and net earnings derived from the sale or other disposition of, the transfer of any interest in, or the licensing of the use of property (other than good will) by an individual whose personal efforts created such property.

(3) Owner-employee. The term "owner-employee" means an employee who—

(A)owns the entire interest in an unincorporated trade or business, or

(B)in the case of a partnership, is a partner who owns more than 10 percent of either the capital interest or the profits interest in such partnership.

To the extent provided in regulations prescribed by the Secretary, such term also means an individual who has been an owner-employee within the meaning of the preceding sentence.

(4) Employer. An individual who owns the entire interest in an unincorporated trade or business shall be treated as his own employer. A partnership shall be treated as the employer of each partner who is an employee within the meaning of paragraph (1).

(5) Contributions on behalf of owner-employees. The term "contribution on behalf of an owner-employee" includes, except as the context otherwise requires, a contribution under a plan—

(A)by the employer for an owner-employee, and

(B)by an owner-employee as an employee.

(6) Special rule for certain fishermen. For purposes of this subsection, the term "self-employed individual" includes an individual described in section 3121(b)(20) [*26 USCS § 3121(b)(20)*] (relating to certain fishermen).

(d) Contribution limit on owner-employees. A trust forming part of a pension or profit-sharing plan which provides contributions or benefits for employees some or all of whom are owner-employees shall constitute a qualified trust under this section only if, in addition to meeting the requirements of subsection (a), the plan provides that contributions on behalf of any owner-employee may be made only with respect to the earned income of such owner-employee which is derived from the trade or business with respect to which such plan is established.

(e) [Repealed]

(f) Certain custodial accounts and contracts. For purposes of this title, a custodial account, an annuity contract, or a contract (other than a life, health or accident, property, casualty, or liability insurance contract) issued by an insurance company qualified to do business in a State shall be treated as a qualified trust under this section if—

(1)the custodial account or contract would, except for the fact that it is not a trust, constitute a qualified trust under this section, and

(2)in the case of a custodial account the assets thereof are held by a bank (as defined in section 408(n) [*26 USCS § 408(n)*]) or another person who demonstrates, to the satisfaction of the Secretary, that the manner in which he will hold the assets will be consistent with the requirements of this section.

For purposes of this title, in the case of a custodial account or contract treated as a qualified trust under this section by reason of this subsection, the person holding the assets of such account or holding such contract shall be treated as the trustee thereof.

(g) Annuity defined. For purposes of this section and sections 402, 403, and 404 [*26 USCS §§ 402*, *403*, and *404*], the term "annuity" includes a face-amount certificate, as defined in section 2(a)(15) of the Investment Company Act of 1940 (*15 U.S.C., sec. 80a-2*); but does not include any contract or certificate issued after December 31, 1962, which is transferable, if any person other than the trustee

of a trust described in section 401(a) [*26 USCS § 401(a)*] which is exempt from tax under section 501(a) [*26 USCS § 501(a)*] is the owner of such contract or certificate.

(h) Medical, etc., benefits for retired employees and their spouses and dependents. Under regulations prescribed by the Secretary, and subject to the provisions of section 420 [*26 USCS § 420*], a pension or annuity plan may provide for the payment of benefits for sickness, accident, hospitalization, and medical expenses of retired employees, their spouses and their dependents, but only if—

(1)such benefits are subordinate to the retirement benefits provided by the plan,

(2)a separate account is established and maintained for such benefits,

(3)the employer's contributions to such separate account are reasonable and ascertainable,

(4)it is impossible, at any time prior to the satisfaction of all liabilities under the plan to provide such benefits, for any part of the corpus or income of such separate account to be (within the taxable year or thereafter) used for, or diverted to, any purpose other than the providing of such benefits,

(5)notwithstanding the provisions of subsection (a)(2), upon the satisfaction of all liabilities under the plan to provide such benefits, any amount remaining in such separate account must, under the terms of the plan, be returned to the employer, and

(6)in the case of an employee who is a key employee, a separate account is established and maintained for such benefits payable to such employee (and his spouse and dependents) and such benefits (to the extent attributable to plan years beginning after March 31, 1984, for which the employee is a key employee) are only payable to such employee (and his spouse and dependents) from such separate account.

For purposes of paragraph (6), the term "key employee" means any employee, who at any time during the plan year or any preceding plan year during which contributions were made on behalf of such employee, is or was a key employee as defined in section 416(i) [*26 USCS § 416(i)*]. In no event shall the requirements of paragraph (1) be treated as met if the aggregate actual contributions for medical benefits, when added to actual contributions for life insurance protection under the plan, exceed 25 percent of the total actual contributions to the plan (other than contributions to fund past service credits) after the date on which the account is established. For purposes of this subsection, the term "dependent" shall include any individual who is a child (as defined in section 152(f)(1) [*26 USCS § 152(f)(1)*]) of a retired employee who as of the end of the calendar year has not attained age 27.

(i) Certain union-negotiated pension plans. In the case of a trust forming part of a pension plan which has been determined by the Secretary to constitute a qualified trust under subsection (a) and to be exempt from taxation under section 501(a) [*26 USCS § 501(a)*] for a period beginning after contributions were first made to or for such trust, if it is shown to the satisfaction of the Secretary that—

(1)such trust was created pursuant to a collective bargaining agreement between employee representatives and one or more employers,

(2)any disbursements of contributions, made to or for such trust before the time as of which the Secretary determined that the trust constituted a qualified trust, substantially complied with the terms of the trust, and the plan of which the trust is a part, as subsequently qualified, and

(3)before the time as of which the Secretary determined that the trust constitutes a qualified trust, the contributions to or for such trust were not used in a manner which would jeopardize the interests of its beneficiaries,

then such trust shall be considered as having constituted a qualified trust under subsection (a) and as having been exempt from taxation under section 501 (a) [*26 USCS § 501(a)*] for the period beginning on the date on which contributions were first made to or for such trust and ending on the date such trust first constituted (without regard to this subsection) a qualified trust under subsection (a).

(j) [Repealed]

(k) Cash or deferred arrangements.

(1) General rule. A profit-sharing or stock bonus plan, a pre-ERISA money purchase plan, or a rural cooperative plan shall not be considered as not satisfying the requirements of subsection (a) merely because the plan includes a qualified cash or deferred arrangement.

(2) Qualified cash or deferred arrangement. A qualified cash or deferred arrangement is any arrangement which is part of a profit-sharing or stock bonus plan, a pre-ERISA money purchase plan, or a rural cooperative plan which meets the requirements of subsection (a)—

(A)under which a covered employee may elect to have the employer make payments as contributions to a trust under the plan on behalf of the employee, or to the employee directly in cash;

(B)under which amounts held by the trust which are attributable to employer contributions made pursuant to the employee's election—

(i)may not be distributable to participants or other beneficiaries earlier than—

(I)severance from employment, death, or disability,

(II)an event described in paragraph (10),

(III)in the case of a profit-sharing or stock bonus plan, the attainment of age 59 ½,

(IV)subject to the provisions of paragraph (14), upon hardship of the employee,

(V)in the case of a qualified reservist distribution (as defined in section 72(t)(2)(G)(iii) [*26 USCS § 72(t)(2)(G)(iii)*]), the date on which a period referred to in subclause (III) of such section begins, or

(VI)except as may be otherwise provided by regulations, with respect to amounts invested in a lifetime income investment (as defined in subsection (a)(38)(B)(ii)), the date that is 90 days prior to the date that such lifetime income investment may no longer be held as an investment option under the arrangement,

(ii)will not be distributable merely by reason of the completion of a stated period of participation or the lapse of a fixed number of years, and

(iii)except as may be otherwise provided by regulations, in the case of amounts described in clause (i)(VI), will be distributed only in the form of a qualified distribution (as defined in subsection (a)(38)(B)(i)) or a qualified plan distribution annuity contract (as defined in subsection (a)(38)(B)(iv)),

(C)which provides that an employee's right to his accrued benefit derived from employer contributions made to the trust pursuant to his election is nonforfeitable, and

(D)which does not require, as a condition of participation in the arrangement, that an employee complete a period of service with the employer (or employers) maintaining the plan extending beyond the period permitted under section 410(a)(1) [*26 USCS § 410(a)(1)*] (determined without regard to subparagraph (B)(i) thereof).

(3) Application of participation and discrimination standards.

(A)A cash or deferred arrangement shall not be treated as a qualified cash or deferred arrangement unless—

(i)those employees eligible to benefit under the arrangement satisfy the provisions of section 410(b)(1) [*26 USCS § 410(b)(1)*], and

(ii)the actual deferral percentage for eligible highly compensated employees (as defined in paragraph (5)) for the plan year bears a relationship to the actual deferral percentage for all other eligible employees for the preceding plan year which meets either of the following tests:

(I) The actual deferral percentage for the group of eligible highly compensated employees is not more than the actual deferral percentage of all other eligible employees multiplied by 1.25.

(II) The excess of the actual deferral percentage for the group of eligible highly compensated employees over that of all other eligible employees is not more than 2 percentage points, and the actual deferral percentage for the group of eligible highly compensated employees is not more than the actual deferral percentage of all other eligible employees multiplied by 2.

If 2 or more plans which include cash or deferred arrangements are considered as 1 plan for purposes of section 401(a)(4) or 410(b) [*26 USCS § 401(a)(4)* or *410(b)*], the cash or deferred arrangements included in such plans shall be treated as 1 arrangement for purposes of this subparagraph.

If any highly compensated employee is a participant under 2 or more cash or deferred arrangements of the employer, for purposes of determining the deferral percentage with respect to such employee, all such cash or deferred arrangements shall be treated as 1 cash or deferred arrangement. An arrangement may apply clause (ii) by using the plan year rather than the preceding plan year if the employer so elects, except that if such an election is made, it may not be changed except as provided by the Secretary.

(B) For purposes of subparagraph (A), the actual deferral percentage for a specified group of employees for a plan year shall be the average of the ratios (calculated separately for each employee in such group) of—

(i)the amount of employer contributions actually paid over to the trust on behalf of each such employee for such plan year, to

(ii)the employee's compensation for such plan year.

(C)A cash or deferred arrangement shall be treated as meeting the requirements of subsection (a)(4) with respect to contributions if the requirements of subparagraph (A)(ii) are met.

(D) For purposes of subparagraph (B), the employer contributions on behalf of any employee—

(i)shall include any employer contributions made pursuant to the employee's election under paragraph (2), and

(ii)under such rules as the Secretary may prescribe, may, at the election of the employer, include—

(I)matching contributions (as defined in 401(m)(4)(A)) which meet the requirements of paragraph (2)(B) and (C), and

(II)qualified nonelective contributions (within the meaning of section 401(m)(4)(C) [*26 USCS § 401(m)(4)(C)*]).

(E) For purposes of this paragraph, in the case of the first plan year of any plan (other than a successor plan), the amount taken into account as the actual deferral percentage of nonhighly compensated employees for the preceding plan year shall be—

(i)3 percent, or

(ii)if the employer makes an election under this subclause, the actual deferral percentage of nonhighly compensated employees determined for such first plan year.

(F) Special rule for early participation. If an employer elects to apply section 410(b)(4)(B) [*26 USCS § 410(b)(4)(B)*] in determining whether a cash or deferred arrangement meets the requirements of subparagraph (A)(i), the employer may, in determining whether the arrangement meets the requirements of subparagraph (A)(ii), exclude from consideration all eligible employees (other than highly compensated employees) who have not met the minimum age and service requirements of section 410(a)(1)(A) [*26 USCS § 410(a)(1)(A)*].

(G) Governmental plan. A governmental plan (within the meaning of section 414(d) [*26 USCS § 414(d)*]) shall be treated as meeting the requirements of this paragraph.

(4) Other requirements.

(A) Benefits (other than matching contributions) must not be contingent on election to defer. A cash or deferred arrangement of any employer shall not be treated as a qualified cash or deferred arrangement if any other benefit is conditioned (directly or indirectly) on the employee electing to have the employer make or not make contributions under the arrangement in lieu of receiving cash. The preceding sentence shall not apply to any matching contribution (as defined in section 401(m) [*26 USCS § 401(m)*]) made by reason of such an election.

(B) Eligibility of state and local governments and tax-exempt organizations.

(i) Tax-exempts eligible. Except as provided in clause (ii), any organization exempt from tax under this subtitle [*26 USCS §§ 1* et seq.] may include a qualified cash or deferred arrangement as part of a plan maintained by it.

(ii) Governments ineligible. A cash or deferred arrangement shall not be treated as a qualified cash or deferred arrangement if it is part of a plan maintained by a State or local government or political subdivision thereof, or any agency or instrumentality thereof. This clause shall not apply to a rural cooperative plan or to a plan of an employer described in clause (iii).

(iii) Treatment of Indian tribal governments. An employer which is an Indian tribal government (as defined in section 7701(a)(40) [*26 USCS § 7701(a)(40)*]), a subdivision of an Indian tribal government (determined in accordance with section 7871(d) [*26 USCS § 7871(d)*]), an agency or instrumentality of an Indian tribal government or subdivision thereof, or a corporation chartered under Federal, State, or tribal law which is owned in whole or in part by any of the foregoing may include a qualified cash or deferred arrangement as part of a plan maintained by the employer.

(C) Coordination with other plans. Except as provided in section 401(m) [*26 USCS § 401(m)*], any employer contribution made pursuant to an employee's election under a qualified cash or deferred arrangement shall not be taken into account for purposes of determining whether any other plan meets the requirements of section 401(a) or 410(b) [*26 USCS § 401(a)* or *410(b)*]. This subparagraph shall not apply for purposes of determining whether a plan meets the average benefit requirement of section 410(b)(2)(A)(ii) [*26 USCS § 410(b)(2)(A)(ii)*].

(5) Highly compensated employee. For purposes of this subsection, the term "highly compensated employee" has the meaning given such term by section 414(q) [*26 USCS § 414(q)*].

(6) Pre-ERISA money purchase plan. For purposes of this subsection, the term "pre-ERISA money purchase plan" means a pension plan—

(A)which is a defined contribution plan (as defined in section 414(i) [*26 USCS § 414(i)*]),

(B)which was in existence on June 27, 1974, and which, on such date, included a salary reduction arrangement, and

(C)under which neither the employee contributions nor the employer contributions may exceed the levels provided for by the contribution formula in effect under the plan on such date.

(7) Rural cooperative plan. For purposes of this subsection—

(A) In general. The term "rural cooperative plan" means any pension plan—

(i)which is a defined contribution plan (as defined in section 414(i) [*26 USCS § 414(i)*]), and

(ii)which is established and maintained by a rural cooperative.

(B) Rural cooperative defined. For purposes of subparagraph (A), the term "rural cooperative" means—

(i)any organization which—

(I)is engaged primarily in providing electric service on a mutual or cooperative basis, or

(II)is engaged primarily in providing electric service to the public in its area of service and which is exempt from tax under this subtitle [*26 USCS §§ 1* et seq.] or which is a State or local government (or an agency or instrumentality thereof), other than a municipality (or an agency or instrumentality thereof),

(ii)any organization described in paragraph (4) or (6) of section 501(c) [*26 USCS § 501(c)*] and at least 80 percent of the members of which are organizations described in clause (i),

(iii)a cooperative telephone company described in section 501(c)(12) [*26 USCS § 501(c)(12)*],

(iv)any organization which—

(I)is a mutual irrigation or ditch company described in section 501(c)(12) [*26 USCS § 501(c)(12)*] (without regard to the 85 percent requirement thereof), or

(II)is a district organized under the laws of a State as a municipal corporation for the purpose of irrigation, water conservation, or drainage, and

(v)an organization which is a national association of organizations described in clause (i), (ii), (iii), or (iv).

(C) Special rule for certain distributions. A rural cooperative plan which includes a qualified cash or deferred arrangement shall not be treated as violating the requirements of section 401(a) [*26 USCS § 401(a)*] or of paragraph (2) merely by reason of a hardship distribution or a distribution to a participant after attainment of age 59 ½ . For purposes of this section, the term "hardship distribution" means a distribution described in paragraph (2)(B)(i)(IV) (without regard to the limitation of its application to profit-sharing or stock bonus plans).

(8) Arrangement not disqualified if excess contributions distributed.

(A) In general. A cash or deferred arrangement shall not be treated as failing to meet the requirements of clause (ii) of paragraph (3)(A) for any plan year if, before the close of the following plan year—

(i)the amount of the excess contributions for such plan year (and any income allocable to such contributions through the end of such year) is distributed, or

(ii)to the extent provided in regulations, the employee elects to treat the amount of the excess contributions as an amount distributed to the employee and then contributed by the employee to the plan.

Any distribution of excess contributions (and income) may be made without regard to any other provision of law.

(B) Excess contributions. For purposes of subparagraph (A), the term "excess contributions" means, with respect to any plan year, the excess of—

(i)the aggregate amount of employer contributions actually paid over to the trust on behalf of highly compensated employees for such plan year, over

(ii)the maximum amount of such contributions permitted under the limitations of clause (ii) of paragraph (3)(A) (determined by reducing contributions made on behalf of highly compensated employees in order of the actual deferral percentages beginning with the highest of such percentages).

(C) Method of distributing excess contributions. Any distribution of the excess contributions for any plan year shall be made to highly compensated employees on the basis of the amount of contributions by, or on behalf of, each of such employees.

(D) Additional tax under section 72(t) [*26 USCS § 72(t)*] not to apply. No tax shall be imposed under section 72(t) [*26 USCS § 72(t)*] on any amount required to be distributed under this paragraph.

(E) Treatment of matching contributions forfeited by reason of excess deferral or contribution or permissible withdrawal. For purposes of paragraph (2)(C), a matching contribution (within the meaning of subsection (m)) shall not be treated as forfeitable merely because such contribution is forfeitable if the contribution to which the matching contribution relates is treated as an excess contribution under subparagraph (B), an excess deferral under section 402(g)(2)(A) [*26 USCS § 402(g)(2)(A)*] a permissible withdrawal under section 414(w) [*26 USCS § 414(e)*], or an excess aggregate contribution under section 401(m)(6)(B) [*26 USCS § 401(m)(6)(B)*].

(F) Cross reference.

For excise tax on certain excess contributions, see section 4979 [*26 USCS § 4979*].

(9) Compensation. For purposes of this subsection, the term "compensation" has the meaning given such term by section 414(s) [*26 USCS § 414(s)*].

(10) Distributions upon termination of plan.

(A) In general. An event described in this subparagraph is the termination of the plan without establishment or maintenance of another defined contribution plan (other than an employee stock ownership plan as defined in section 4975(e)(7) [*26 USCS § 4975(e)(7)*]).

(B) Distributions must be lump sum distributions.

(i) In general. A termination shall not be treated as described in subparagraph (A) with respect to any employee unless the employee receives a lump sum distribution by reason of the termination.

(ii) Lump-sum distribution. For purposes of this subparagraph, the term "lump-sum distribution" has the meaning given such term by section 402(e)(4)(D) [*26 USCS § 402(e)(4)(D)*] (without regard to subclauses (I), (II), (III), and (IV) of clause (i) thereof). Such term includes a distribution of an annuity contract from—

(I)a trust which forms a part of a plan described in section 401(a) [*26 USCS § 401(a)*] and which is exempt from tax under section 501(a) [*26 USCS § 501(a)*], or

(II)an annuity plan described in section 403(a) [*26 USCS § 403(a)*].

(11) Adoption of simple plan to meet nondiscrimination tests.

(A) In general. A cash or deferred arrangement maintained by an eligible employer shall be treated as meeting the requirements of paragraph (3)(A)(ii) if such arrangement meets—

(i)the contribution requirements of subparagraph (B),

(ii)the exclusive plan requirements of subparagraph (C), and

(iii)the vesting requirements of section 408(p)(3) [*26 USCS § 408(p)(3)*].

(B) Contribution requirements.

(i) In general. The requirements of this subparagraph are met if, under the arrangement—

(I)an employee may elect to have the employer make elective contributions for the year on behalf of the employee to a trust under the plan in an amount which is expressed as a percentage of compensation of the employee but which in no event exceeds the amount in effect under section 408(p)(2)(A)(ii) [*26 USCS § 408(p)(2)(8)(ii)*],

(II)the employer is required to make a matching contribution to the trust for the year in an amount equal to so much of the amount the employee elects under subclause (I) as does not exceed 3 percent of compensation for the year, and

(III)no other contributions may be made other than contributions described in subclause (I) or (II).

(ii) Employer may elect 2-percent nonelective contribution. An employer shall be treated as meeting the requirements of clause (i)(II) for any year if, in lieu of the contributions described in such clause, the employer elects (pursuant to the terms of the arrangement) to make nonelective contributions of 2 percent of compensation for each employee who is eligible to participate in the arrangement and who has at least $5,000 of compensation from the employer for the year. If an employer makes an election under this subparagraph for any year, the employer shall notify employees of such election within a reasonable period of time before the 60th day before the beginning of such year.

(iii) Administrative requirements.

(I) In general. Rules similar to the rules of subparagraphs (B) and (C) of section 408(p)(5) [*26 USCS § 408(p)(5)*] shall apply for purposes of this subparagraph.

(II) Notice of election period. The requirements of this subparagraph shall not be treated as met with respect to any year unless the employer notifies each employee eligible to participate, within a reasonable period of time before the 60th day before the beginning of such year (and, for the first year the employee is so eligible, the 60th day before the first day such employee is so eligible), of the rules similar to the rules of section 408(p)(5)(C) [*26 USCS § 408(p)(5)(C)*] which apply by reason of subclause (I).

(C) Exclusive plan requirement. The requirements of this subparagraph are met for any year to which this paragraph applies if no contributions were made, or benefits were accrued, for services during such year under any qualified plan of the employer on behalf of any

employee eligible to participate in the cash or deferred arrangement, other than contributions described in subparagraph (B).

(D) Definitions and special rule.

(i) Definitions. For purposes of this paragraph, any term used in this paragraph which is also used in section 408(p) [*26 USCS § 408(p)*] shall have the meaning given such term by such section.

(ii) Coordination with top-heavy rules. A plan meeting the requirements of this paragraph for any year shall not be treated as a top-heavy plan under section 416 [*26 USCS § 416*] for such year if such plan allows only contributions required under this paragraph.

(12) Alternative methods of meeting nondiscrimination requirements.

(A) In general. A cash or deferred arrangement shall be treated as meeting the requirements of paragraph (3)(A)(ii) if such arrangement—

(i)meets the contribution requirements of subparagraph (B) and the notice requirements of subparagraph (D), or

(ii)meets the contribution requirements of subparagraph (C).

(B) Matching contributions.

(i) In general. The requirements of this subparagraph are met if, under the arrangement, the employer makes matching contributions on behalf of each employee who is not a highly compensated employee in an amount equal to—

(I)100 percent of the elective contributions of the employee to the extent such elective contributions do not exceed 3 percent of the employee's compensation, and

(II)50 percent of the elective contributions of the employee to the extent that such elective contributions exceed 3 percent but do not exceed 5 percent of the employee's compensation.

(ii) Rate for highly compensated employees. The requirements of this subparagraph are not met if, under the arrangement, the rate of matching contribution with respect to any elective contribution of a highly compensated employee at any rate of elective contribution is greater than that with respect to an employee who is not a highly compensated employee.

(iii) Alternative plan designs. If the rate of any matching contribution with respect to any rate of elective contribution is not equal to the percentage required under clause (i), an arrangement shall not be treated as failing to meet the requirements of clause (i) if—

(I)the rate of an employer's matching contribution does not increase as an employee's rate of elective contributions increase, and

(II)the aggregate amount of matching contributions at such rate of elective contribution is at least equal to the aggregate amount of matching contributions which would be made if matching contributions were made on the basis of the percentages described in clause (i).

(C) Nonelective contributions. The requirements of this subparagraph are met if, under the arrangement, the employer is required, without regard to whether the employee makes an elective contribution or employee contribution, to make a contribution to a defined contribution plan on behalf of each employee who is not a highly compensated employee and who is eligible to participate in the arrangement in an amount equal to at least 3 percent of the employee's compensation.

(D) Notice requirement. An arrangement meets the requirements of this paragraph if, under the arrangement, each employee eligible to participate is, within a reasonable period before any year, given written notice of the employee's rights and obligations under the arrangement which—

(i)is sufficiently accurate and comprehensive to apprise the employee of such rights and obligations, and

(ii)is written in a manner calculated to be understood by the average employee eligible to participate.

(E) Other requirements.

(i) Withdrawal and vesting restrictions. An arrangement shall not be treated as meeting the requirements of subparagraph (B) or (C) of this paragraph unless the requirements of subparagraphs (B) and (C) of paragraph (2) are met with respect to all employer contributions (including matching contributions) taken into account in determining whether the requirements of subparagraphs (B) and (C) of this paragraph are met.

(ii) Social security and similar contributions not taken into account. An arrangement shall not be treated as meeting the requirements of subparagraph (B) or (C) unless such requirements are met without regard to subsection (l), and, for purposes of subsection (l), employer contributions under subparagraph (B) or (C) shall not be taken into account.

(F) Timing of a plan amendment for employer making nonelective contributions.

(i) In general. Except as provided in clause (ii), a plan may be amended after the beginning of a plan year to provide that the requirements of subparagraph (C) shall apply to the arrangement for the plan year, but only if the amendment is adopted—

(I)at any time before the 30th day before the close of the plan year, or

(II)at any time before the last day under paragraph (8)(A) for distributing excess contributions for the plan year.

(ii) Exception where plan provided for matching contributions. Clause (i) shall not apply to any plan year if the plan provided at any time during the plan year that the requirements of subparagraph (B) or paragraph (13)(D)(i)(I) applied to the plan year.

(iii)4-percent contribution requirement. Clause (i)(II) shall not apply to an arrangement unless the amount of the contributions described in subparagraph (C) which the employer is required to make under the arrangement for the plan year with respect to any employee is an amount equal to at least 4 percent of the employee's compensation.

(G) Other plans. An arrangement shall be treated as meeting the requirements under subparagraph (A)(i) if any other plan maintained by the employer meets such requirements with respect to employees eligible under the arrangement.

(13) Alternative method for automatic contribution arrangements to meet nondiscrimination requirements.

(A) In general. A qualified automatic contribution arrangement shall be treated as meeting the requirements of paragraph (3)(A)(ii).

(B) Qualified automatic contribution arrangement. For purposes of this paragraph, the term "qualified automatic contribution arrangement" means a cash or deferred arrangement—

(i)which is described in subparagraph (D)(i)(I) and meets the applicable requirements of subparagraphs (C) through (E), or

(ii)which is described in subparagraph (D)(i)(II) and meets the applicable requirements of subparagraphs (C) and (D).

(C) Automatic deferral.

(i) In general. The requirements of this subparagraph are met if, under the arrangement, each employee eligible to participate in the arrangement is treated as having elected to have the employer make elective contributions in an amount equal to a qualified percentage of compensation.

(ii) Election out. The election treated as having been made under clause (i) shall cease to apply with respect to any employee if such employee makes an affirmative election—

(I)to not have such contributions made, or

(II)to make elective contributions at a level specified in such affirmative election.

(iii) Qualified percentage. For purposes of this subparagraph, the term "qualified percentage" means, with respect to any employee, any percentage determined under the arrangement if such percentage is applied uniformly, does not exceed 15 percent (10 percent during the period described in subclause (I)), and is at least—

(I)3 percent during the period ending on the last day of the first plan year which begins after the date on which the first elective contribution described in clause (i) is made with respect to such employee,

(II)4 percent during the first plan year following the plan year described in subclause (I),

(III)5 percent during the second plan year following the plan year described in subclause (I), and

(IV)6 percent during any subsequent plan year.

(iv) Automatic deferral for current employees not required. Clause (i) may be applied without taking into account any employee who—

(I)was eligible to participate in the arrangement (or a predecessor arrangement) immediately before the date on which such arrangement becomes a qualified

automatic contribution arrangement (determined after application of this clause), and

(II)had an election in effect on such date either to participate in the arrangement or to not participate in the arrangement.

(D) Matching or nonelective contributions.

(i) In general. The requirements of this subparagraph are met if, under the arrangement, the employer—

(I)makes matching contributions on behalf of each employee who is not a highly compensated employee in an amount equal to the sum of 100 percent of the elective contributions of the employee to the extent that such contributions do not exceed 1 percent of compensation plus 50 percent of so much of such contributions as exceed 1 percent but do not exceed 6 percent of compensation, or

(II)is required, without regard to whether the employee makes an elective contribution or employee contribution, to make a contribution to a defined contribution plan on behalf of each employee who is not a highly compensated employee and who is eligible to participate in the arrangement in an amount equal to at least 3 percent of the employee's compensation.

(ii) Application of rules for matching contributions. The rules of clauses (ii) and (iii) of paragraph (12)(B) shall apply for purposes of clause (i)(I).

(iii) Withdrawal and vesting restrictions. An arrangement shall not be treated as meeting the requirements of clause (i) unless, with respect to employer contributions (including matching contributions) taken into account in determining whether the requirements of clause (i) are met—

(I)any employee who has completed at least 2 years of service (within the meaning of section 411(a) [*26 USCS § 411(a)*]) has a nonforfeitable right to 100 percent of the employee's accrued benefit derived from such employer contributions, and

(II)the requirements of subparagraph (B) of paragraph (2) are met with respect to all such employer contributions.

(iv) Application of certain other rules. The rules of subparagraphs (E)(ii) and (F) of paragraph (12) shall apply for purposes of subclauses (I) and (II) of clause (i).

(E) Notice requirements.

(i) In general. The requirements of this subparagraph are met if, within a reasonable period before each plan year, each employee eligible to participate in the arrangement for such year receives written notice of the employee's rights and obligations under the arrangement which—

(I)is sufficiently accurate and comprehensive to apprise the employee of such rights and obligations, and

(II)is written in a manner calculated to be understood by the average employee to whom the arrangement applies.

(ii) Timing and content requirements. A notice shall not be treated as meeting the requirements of clause (i) with respect to an employee unless—

(I)the notice explains the employee's right under the arrangement to elect not to have elective contributions made on the employee's behalf (or to elect to have such contributions made at a different percentage),

(II)in the case of an arrangement under which the employee may elect among 2 or more investment options, the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the employee, and

(III)the employee has a reasonable period of time after receipt of the notice described in subclauses (I) and (II) and before the first elective contribution is made to make either such election.

(F) Timing of plan amendment for employer making nonelective contributions.

(i) In general. Except as provided in clause (ii), a plan may be amended after the beginning of a plan year to provide that the requirements of subparagraph (C) shall apply to the arrangement for the plan year, but only if the amendment is adopted—

(I)at any time before the 30th day before the close of the plan year, or

(II)at any time before the last day under paragraph (8)(A) for distributing excess contributions for the plan year.

(ii) Exception where plan provided for matching contributions. Clause (i) shall not apply to any plan year if the plan provided at any time during the plan year that the requirements of subparagraph (D)(i)(I) or paragraph (12)(B) applied to the plan year.

(iii)4-percent contribution requirement. Clause (i)(II) shall not apply to an arrangement unless the amount of the contributions described in subparagraph (D)(i)(II) which the employer is required to make under the arrangement for the plan year with respect to any employee is an amount equal to at least 4 percent of the employee's compensation

(14) Special rules relating to hardship withdrawals. For purposes of paragraph (2)(B)(i)(IV)—

(A) Amounts which may be withdrawn. The following amounts may be distributed upon hardship of the employee:

(i) Contributions to a profit-sharing or stock bonus plan to which section 402(e)(3) [*26 USCS § 402(e)(3)*] applies.

(ii) Qualified nonelective contributions (as defined in subsection (m)(4)(C)).

(iii) Qualified matching contributions described in paragraph (3)(D)(ii)(I).

(iv) Earnings on any contributions described in clause (i), (ii), or (iii).

(B) No requirement to take available loan. A distribution shall not be treated as failing to be made upon the hardship of an employee solely because the employee does not take any available loan under the plan.

(l) Permitted disparity in plan contributions or benefits.

(1) In general. The requirements of this subsection are met with respect to a plan if—

(A)in the case of a defined contribution plan, the requirements of paragraph (2) are met, and

(B)in the case of a defined benefit plan, the requirements of paragraph (3) are met.

(2) Defined contribution plan.

(A) In general. A defined contribution plan meets the requirements of this paragraph if the excess contribution percentage does not exceed the base contribution percentage by more than the lesser of—

(i)the base contribution percentage, or

(ii)the greater of—

(I)5.7 percentage points, or

(II)the percentage equal to the portion of the rate of tax under section 3111(a) [*26 USCS § 3111(a)*] (in effect as of the beginning of the year) which is attributable to old-age insurance.

(B) Contribution percentages.—

(i) Excess contribution percentage. The term "excess contribution percentage" means the percentage of compensation which is contributed by the employer under the plan with respect to that portion of each participant's compensation in excess of the integration level.

(ii) Base contribution percentage. The term "base contribution percentage" means the percentage of compensation contributed by the employer under the plan with respect to that portion of each participant's compensation not in excess of the integration level.

(3) Defined benefit plan. A defined benefit plan meets the requirements of this paragraph if—

(A) Excess plans.

(i) In general. In the case of a plan other than an offset plan—

(I)the excess benefit percentage does not exceed the base benefit percentage by more than the maximum excess allowance,

(II)any optional form of benefit, preretirement benefit, actuarial factor, or other benefit or feature provided with respect to compensation in excess of the integration level is provided with respect to compensation not in excess of such level, and

(III)benefits are based on average annual compensation.

(ii) Benefit percentages. For purposes of this subparagraph, the excess and base benefit percentages shall be computed in the same manner as the excess and base contribution percentages under paragraph (2)(B), except that such determination shall be made on the basis of benefits attributable to employer contributions rather than contributions.

(B) Offset plans. In the case of an offset plan, the plan provides that—

(i)a participant's accrued benefit attributable to employer contributions (within the meaning of section 411(c)(1) [*26 USCS § 411(c)(1)*]) may not be reduced (by reason of the offset) by more than the maximum offset allowance, and

(ii)benefits are based on average annual compensation.

(4) Definitions relating to paragraph (3). For purposes of paragraph (3)—

(A) Maximum excess allowance. The maximum excess allowance is equal to—

(i)in the case of benefits attributable to any year of service with the employer taken into account under the plan, ¾ of a percentage point, and

(ii)in the case of total benefits, ¾ of a percentage point, multiplied by the participant's years of service (not in excess of 35) with the employer taken into account under the plan.

In no event shall the maximum excess allowance exceed the base benefit percentage.

(B) Maximum offset allowance. The maximum offset allowance is equal to—

(i)in the case of benefits attributable to any year of service with the employer taken into account under the plan, ¾ percent of the participant's final average compensation, and

(ii)in the case of total benefits, ¾ percent of the participant's final average compensation, multiplied by the participant's years of service (not in excess of 35) with the employer taken into account under the plan.

In no event shall the maximum offset allowance exceed 50 percent of the benefit which would have accrued without regard to the offset reduction.

(C) Reductions.

(i) In general. The Secretary shall prescribe regulations requiring the reduction of the ¾ percentage factor under subparagraph (A) or (B)—

(I)in the case of a plan other than an offset plan which has an integration level in excess of covered compensation, or

(II)with respect to any participant in an offset plan who has final average compensation in excess of covered compensation.

(ii) Basis of reductions. Any reductions under clause (i) shall be based on the percentages of compensation replaced by the employer-derived portions of primary insurance amounts under the Social Security Act [*42 USCS §§ 301* et seq.] for participants with compensation in excess of covered compensation.

(D) Offset plan. The term "offset plan" means any plan with respect to which the benefit attributable to employer contributions for each participant is reduced by an amount specified in the plan.

(5) Other definitions and special rules. For purposes of this subsection—

(A) Integration level.

(i) In general. The term "integration level" means the amount of compensation specified under the plan (by dollar amount or formula) at or below which the rate at which

contributions or benefits are provided (expressed as a percentage) is less than such rate above such amount.

(ii) Limitation. The integration level for any year may not exceed the contribution and benefit base in effect under section 230 of the Social Security Act [*42 USCS § 430*] for such year.

(iii) Level to apply to all participants. A plan's integration level shall apply with respect to all participants in the plan.

(iv) Multiple integration levels. Under rules prescribed by the Secretary, a defined benefit plan may specify multiple integration levels.

(B) Compensation. The term "compensation" has the meaning given such term by section 414(s) [*26 USCS § 414(s)*].

(C) Average annual compensation. The term "average annual compensation" means the participant's highest average annual compensation for—

(i)any period of at least 3 consecutive years, or

(ii)if shorter, the participant's full period of service.

(D) Final average compensation.

(i) In general. The term "final average compensation" means the participant's average annual compensation for—

(I)the 3-consecutive year period ending with the current year, or

(II)if shorter, the participant's full period of service.

(ii) Limitation. A participant's final average compensation shall be determined by not taking into account in any year compensation in excess of the contribution and benefit base in effect under section 230 of the Social Security Act [*42 USCS § 430*] for such year.

(E) Covered compensation.

(i) In general. The term "covered compensation" means, with respect to an employee, the average of the contribution and benefit bases in effect under section 230 of the Social Security Act [*42 USCS § 430*] for each year in the 35-year period ending with the year in which the employee attains the social security retirement age.

(ii) Computation for any year. For purposes of clause (i), the determination for any year preceding the year in which the employee attains the social security retirement age shall be made by assuming that there is no increase in the bases described in clause (i) after the determination year and before the employee attains the social security retirement age.

(iii) Social security retirement age. For purposes of this subparagraph, the term "social security retirement age" has the meaning given such term by section 415(b)(8) [*26 USCS § 415(b)(8)*].

(F) Regulations. The Secretary shall prescribe such regulations as are necessary or appropriate to carry out the purposes of this subsection, including—

(i)in the case of a defined benefit plan which provides for unreduced benefits commencing before the social security retirement age (as defined in section 415(b)(8) [*26 USCS § 415(b)(8)*]), rules providing for the reduction of the maximum excess allowance and the maximum offset allowance, and

(ii)in the case of an employee covered by 2 or more plans of the employer which fail to meet the requirements of subsection (a)(4) (without regard to this subsection), rules preventing the multiple use of the disparity permitted under this subsection with respect to any employee.

For purposes of clause (i), unreduced benefits shall not include benefits for disability (within the meaning of section 223(d) of the Social Security Act [*42 USCS § 423(d)*]).

(6) Special rule for plan maintained by railroads. In determining whether a plan which includes employees of a railroad employer who are entitled to benefits under the Railroad Retirement Act of 1974 meets the requirements of this subsection, rules similar to the rules set forth in this subsection shall apply. Such rules shall take into account the employer-derived portion of the employees' tier 2 railroad retirement benefits and any supplemental annuity under the Railroad Retirement Act of 1974.

(m) Nondiscrimination test for matching contributions and employee contributions.

(1) In general. A defined contribution plan shall be treated as meeting the requirements of subsection (a)(4) with respect to the amount of any matching contribution or employee contribution for any plan year only if the contribution percentage requirement of paragraph (2) of this subsection is met for such plan year.

(2) Requirements.

(A) Contribution percentage requirement. A plan meets the contribution percentage requirement of this paragraph for any plan year only if the contribution percentage for eligible highly compensated employees for such plan year does not exceed the greater of—

(i)125 percent of such percentage for all other eligible employees for the preceding plan year, or

(ii)the lesser of 200 percent of such percentage for all other eligible employees for the preceding plan year, or such percentage for all other eligible employees for the preceding plan year plus 2 percentage points.

This subparagraph may be applied by using the plan year rather than the preceding plan year if the employer so elects, except that if such an election is made, it may not be changed except as provided by the Secretary.

(B) Multiple plans treated as a single plan. If two or more plans of an employer to which matching contributions, employee contributions, or elective deferrals are made are treated as one plan for purposes of section 410(b) [*26 USCS § 410(b)*], such plans shall be treated as one plan for purposes of this subsection. If a highly compensated employee participates in two or more plans of an employer to which contributions to which this subsection applies are made, all such contributions shall be aggregated for purposes of this subsection.

(3) Contribution percentage. For purposes of paragraph (2), the contribution percentage for a specified group of employees for a plan year shall be the average of the ratios (calculated separately for each employee in such group) of—

(A)the sum of the matching contributions and employee contributions paid under the plan on behalf of each such employee for such plan year, to

(B)the employee's compensation (within the meaning of section 414(s) [*26 USCS § 414(s)*]) for such plan year.

Under regulations, an employer may elect to take into account (in computing the contribution percentage) elective deferrals and qualified nonelective contributions under the plan or any other plan of the employer. If matching contributions are taken into account for purposes of subsection (k)(3)(A)(ii) for any plan year, such contributions shall not be taken into account under subparagraph (A) for such year. Rules similar to the rules of subsection (k)(3)(E) shall apply for purposes of this subsection.

(4) Definitions. For purposes of this subsection—

(A) Matching contribution. The term "matching contribution" means—

(i)any employer contribution made to a defined contribution plan on behalf of an employee on account of an employee contribution made by such employee, and

(ii)any employer contribution made to a defined contribution plan on behalf of an employee on account of an employee's elective deferral.

(B) Elective deferral. The term "elective deferral" means any employer contribution described in section 402(g)(3) [*26 USCS § 402(g)(3)*].

(C) Qualified nonelective contributions. The term "qualified nonelective contribution" means any employer contribution (other than a matching contribution) with respect to which—

(i)the employee may not elect to have the contribution paid to the employee in cash instead of being contributed to the plan, and

(ii)the requirements of subparagraphs (B) and (C) of subsection (k)(2) are met.

(5) Employees taken into consideration.

(A) In general. Any employee who is eligible to make an employee contribution (or, if the employer takes elective contributions into account, elective contributions) or to receive a matching contribution under the plan being tested under paragraph (1) shall be considered an eligible employee for purposes of this subsection.

(B) Certain nonparticipants. If an employee contribution is required as a condition of participation in the plan, any employee who would be a participant in the plan if such employee made such a contribution shall be treated as an eligible employee on behalf of whom no employer contributions are made.

(C) Special rule for early participation. If an employer elects to apply section 410(b)(4)(B) [*26 USCS § 410(b)(4)(B)*] in determining whether a plan meets the requirements of section 410(b) [*26 USCS § 410(b)*], the employer may, in determining whether the plan meets the requirements of paragraph (2), exclude from consideration all eligible employees (other

than highly compensated employees) who have not met the minimum age and service requirements of section 410(a)(1)(A) [*26 USCS § 410(a)(1)(A)*].

(6) Plan not disqualified if excess aggregate contributions distributed before end of following plan year.

(A) In general. A plan shall not be treated as failing to meet the requirements of paragraph (1) for any plan year if, before the close of the following plan year, the amount of the excess aggregate contributions for such plan year (and any income allocable to such contributions through the end of such year) is distributed (or, if forfeitable, is forfeited). Such contributions (and such income) may be distributed without regard to any other provision of law.

(B) Excess aggregate contributions. For purposes of subparagraph (A), the term "excess aggregate contributions" means, with respect to any plan year, the excess of—

(i)the aggregate amount of the matching contributions and employee contributions (and any qualified nonelective contribution or elective contribution taken into account in computing the contribution percentage) actually made on behalf of highly compensated employees for such plan year, over

(ii)the maximum amount of such contributions permitted under the limitations of paragraph (2)(A) (determined by reducing contributions made on behalf of highly compensated employees in order of their contribution percentages beginning with the highest of such percentages).

(C) Method of distributing excess aggregate contributions. Any distribution of the excess aggregate contributions for any plan year shall be made to highly compensated employees on the basis of the amount of contributions on behalf of, or by, each such employee. Forfeitures of excess aggregate contributions may not be allocated to participants whose contributions are reduced under this paragraph.

(D) Coordination with subsection (k) and 402(g). The determination of the amount of excess aggregate contributions with respect to a plan shall be made after—

(i)first determining the excess deferrals (within the meaning of section 402(g) [*26 USCS § 402(g)*]), and

(ii)then determining the excess contributions under subsection (k).

(7) Treatment of distributions.

(A) Additional tax of section 72(t) [*26 USCS § 72(t)*] not applicable. No tax shall be imposed under section 72(t) [*26 USCS § 72(t)*] on any amount required to be distributed under paragraph (6).

(B) Exclusion of employee contributions. Any distribution attributable to employee contributions shall not be included in gross income except to the extent attributable to income on such contributions.

(8) Highly compensated employee. For purposes of this subsection, the term "highly compensated employee" has the meaning given to such term by section 414(q) [*26 USCS § 414(q)*].

(9) Regulations. The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this subsection and subsection (k), including regulations permitting appropriate aggregation of plans and contributions.

(10) Alternative method of satisfying tests. A defined contribution plan shall be treated as meeting the requirements of paragraph (2) with respect to matching contributions if the plan—

(A)meets the contribution requirements of subparagraph (B) of subsection (k)(11),

(B)meets the exclusive plan requirements of subsection (k)(11)(C), and

(C)meets the vesting requirements of section 408(p)(3) [*26 USCS § 408(p)(3)*].

(11) Additional alternative method of satisfying tests.

(A) In general. A defined contribution plan shall be treated as meeting the requirements of paragraph (2) with respect to matching contributions if the plan—

(i)meets the contribution requirements of subparagraph (B) or (C) of subsection (k)(12),

(ii)meets the notice requirements of subsection (k)(12)(D), and

(iii)meets the requirements of subparagraph (B).

(B) Limitation on matching contributions. The requirements of this subparagraph are met if—

(i)matching contributions on behalf of any employee may not be made with respect to an employee's contributions or elective deferrals in excess of 6 percent of the employee's compensation,

(ii)the rate of an employer's matching contribution does not increase as the rate of an employee's contributions or elective deferrals increase, and

(iii)the matching contribution with respect to any highly compensated employee at any rate of an employee contribution or rate of elective deferral is not greater than that with respect to an employee who is not a highly compensated employee.

(12) Alternative method for automatic contribution arrangements. A defined contribution plan shall be treated as meeting the requirements of paragraph (2) with respect to matching contributions if the plan—

(A)is a qualified automatic contribution arrangement (as defined in subsection (k)(13)), and

(B)meets the requirements of paragraph (11)(B).

(13) Cross reference. For excise tax on certain excess contributions, see section 4979 [*26 USCS § 4979*].

(n) Coordination with qualified domestic relations orders. The Secretary shall prescribe such rules or regulations as may be necessary to coordinate the requirements of subsection (a)(13)(B) and section 414(p) [*26 USCS § 414(p)*] (and the regulations issued by the Secretary of Labor thereunder) with the other provisions of this chapter [*26 USCS §§ 1* et seq.].

(o) Special rules for applying nondiscrimination rules to protect older, longer service and grandfathered participants.

(1) Testing of defined benefit plans with closed classes of participants.

(A) Benefits, rights, or features provided to closed classes. A defined benefit plan which provides benefits, rights, or features to a closed class of participants shall not fail to satisfy the requirements of subsection (a)(4) by reason of the composition of such closed class or the benefits, rights, or features provided to such closed class, if—

(i)for the plan year as of which the class closes and the 2 succeeding plan years, such benefits, rights, and features satisfy the requirements of subsection (a)(4) (without regard to this subparagraph but taking into account the rules of subparagraph (I)),

(ii)after the date as of which the class was closed, any plan amendment which modifies the closed class or the benefits, rights, and features provided to such closed class does not discriminate significantly in favor of highly compensated employees, and

(iii)the class was closed before April 5, 2017, or the plan is described in subparagraph (C).

(B) Aggregate testing with defined contribution plans permitted on a benefits basis.

(i) In general. For purposes of determining compliance with subsection (a)(4) and section 410(b) [*26 USCS § 410(b)*], a defined benefit plan described in clause (iii) may be aggregated and tested on a benefits basis with 1 or more defined contribution plans, including with the portion of 1 or more defined contribution plans which—

(I)provides matching contributions (as defined in subsection (m)(4)(A)),

(II)provides annuity contracts described in section 403(b) [*26 USCS § 403(b)*] which are purchased with matching contributions or nonelective contributions, or

(III)consists of an employee stock ownership plan (within the meaning of section 4975(e)(7) [*26 USCS § 4975(e)(7)*]) or a tax credit employee stock ownership plan (within the meaning of section 409(a) [*26 USCS § 409(a)*]).

(ii) Special rules for matching contributions. For purposes of clause (i), if a defined benefit plan is aggregated with a portion of a defined contribution plan providing matching contributions—

(I)such defined benefit plan must also be aggregated with any portion of such defined contribution plan which provides elective deferrals described in subparagraph (A) or (C) of section 402(g)(3) [*26 USCS § 402(g)(3)*], and

(II)such matching contributions shall be treated in the same manner as nonelective contributions, including for purposes of applying the rules of subsection (l).

(iii) Plans described. A defined benefit plan is described in this clause if—

(I)the plan provides benefits to a closed class of participants,

(II)for the plan year as of which the class closes and the 2 succeeding plan years, the plan satisfies the requirements of section 410(b) [*26 USCS § 410(b)*] and subsection (a)(4) (without regard to this subparagraph but taking into account the rules of subparagraph (I)),

(III)after the date as of which the class was closed, any plan amendment which modifies the closed class or the benefits provided to such closed class does not discriminate significantly in favor of highly compensated employees, and

(IV)the class was closed before April 5, 2017, or the plan is described in subparagraph (C).

(C) Plans described. A plan is described in this subparagraph if, taking into account any predecessor plan—

(i)such plan has been in effect for at least 5 years as of the date the class is closed, and

(ii)during the 5-year period preceding the date the class is closed, there has not been a substantial increase in the coverage or value of the benefits, rights, or features described in subparagraph (A) or in the coverage or benefits under the plan described in subparagraph (B)(iii) (whichever is applicable).

(D) Determination of substantial increase for benefits, rights, and features. In applying subparagraph (C)(ii) for purposes of subparagraph (A)(iii), a plan shall be treated as having had a substantial increase in coverage or value of the benefits, rights, or features described in subparagraph (A) during the applicable 5-year period only if, during such period—

(i)the number of participants covered by such benefits, rights, or features on the date such period ends is more than 50 percent greater than the number of such participants on the first day of the plan year in which such period began, or

(ii)such benefits, rights, and features have been modified by 1 or more plan amendments in such a way that, as of the date the class is closed, the value of such benefits, rights, and features to the closed class as a whole is substantially greater than the value as of the first day of such 5-year period, solely as a result of such amendments.

(E) Determination of substantial increase for aggregate testing on benefits basis. In applying subparagraph (C)(ii) for purposes of subparagraph (B)(iii)(IV), a plan shall be treated as having had a substantial increase in coverage or benefits during the applicable 5-year period only if, during such period—

(i)the number of participants benefitting under the plan on the date such period ends is more than 50 percent greater than the number of such participants on the first day of the plan year in which such period began, or

(ii)the average benefit provided to such participants on the date such period ends is more than 50 percent greater than the average benefit provided on the first day of the plan year in which such period began.

(F) Certain employees disregarded. For purposes of subparagraphs (D) and (E), any increase in coverage or value or in coverage or benefits, whichever is applicable, which is attributable to such coverage and value or coverage and benefits provided to employees—

(i)who became participants as a result of a merger, acquisition, or similar event which occurred during the 7-year period preceding the date the class is closed, or

(ii)who became participants by reason of a merger of the plan with another plan which had been in effect for at least 5 years as of the date of the merger,

shall be disregarded, except that clause (ii) shall apply for purposes of subparagraph (D) only if, under the merger, the benefits, rights, or features under 1 plan are conformed to the benefits, rights, or features of the other plan prospectively.

(G) Rules relating to average benefit. For purposes of subparagraph (E)—

(i)the average benefit provided to participants under the plan will be treated as having remained the same between the 2 dates described in subparagraph (E)(ii) if the benefit formula applicable to such participants has not changed between such dates, and

(ii)if the benefit formula applicable to 1 or more participants under the plan has changed between such 2 dates, then the average benefit under the plan shall be considered to have increased by more than 50 percent only if—

(I)the total amount determined under section 430(b)(1)(A)(i) [*26 USCS § 430(b)(1)(A)(i)*] for all participants benefitting under the plan for the plan year in which the 5-year period described in subparagraph (E) ends, exceeds

(II)the total amount determined under section 430(b)(1)(A)(i) [*26 USCS § 430(b)(1)(A)(i)*] for all such participants for such plan year, by using the benefit formula in effect for each such participant for the first plan year in such 5-year period,

by more than 50 percent. In the case of a CSEC plan (as defined in section 414(y) [*26 USCS § 414(y)*]), the normal cost of the plan (as determined under section 433(j)(1)(B) [*26 USCS § 433(j)(1)(B)*]) shall be used in lieu of the amount determined under section 430(b)(1)(A)(i) [*26 USCS § 430(b)(1)(A)(i)*].

(H) Treatment as single plan. For purposes of subparagraphs (E) and (G), a plan described in section 413(c) [*26 USCS § 413(c)*] shall be treated as a single plan rather than as separate plans maintained by each employer in the plan.

(I) Special rules. For purposes of subparagraphs (A)(i) and (B)(iii)(II), the following rules shall apply:

(i) In applying section 410(b)(6)(C) [*26 USCS § 410(b)(6)(C)*], the closing of the class of participants shall not be treated as a significant change in coverage under section 410(b)(6)(C)(i)(II) [*26 USCS § 410(b)(6)(C)(i)(II)*].

(ii)2 or more plans shall not fail to be eligible to be aggregated and treated as a single plan solely by reason of having different plan years.

(iii) Changes in the employee population shall be disregarded to the extent attributable to individuals who become employees or cease to be employees, after the date the class is closed, by reason of a merger, acquisition, divestiture, or similar event.

(iv) Aggregation and all other testing methodologies otherwise applicable under subsection (a)(4) and section 410(b) [*26 USCS § 410(b)*] may be taken into account.

The rule of clause (ii) shall also apply for purposes of determining whether plans to which subparagraph (B)(i) applies may be aggregated and treated as 1 plan for purposes of

determining whether such plans meet the requirements of subsection (a)(4) and section 410(b) [*26 USCS § 410(b)*].

(J) Spun-off plans. For purposes of this paragraph, if a portion of a defined benefit plan described in subparagraph (A) or (B)(iii) is spun off to another employer and the spun-off plan continues to satisfy the requirements of—

(i)subparagraph (A)(i) or (B)(iii)(II), whichever is applicable, if the original plan was still within the 3-year period described in such subparagraph at the time of the spin off, and

(ii)subparagraph (A)(ii) or (B)(iii)(III), whichever is applicable,

the treatment under subparagraph (A) or (B) of the spun-off plan shall continue with respect to such other employer.

(2) Testing of defined contribution plans.

(A) Testing on a benefits basis. A defined contribution plan shall be permitted to be tested on a benefits basis if—

(i)such defined contribution plan provides make-whole contributions to a closed class of participants whose accruals under a defined benefit plan have been reduced or eliminated,

(ii)for the plan year of the defined contribution plan as of which the class eligible to receive such make-whole contributions closes and the 2 succeeding plan years, such closed class of participants satisfies the requirements of section 410(b)(2)(A)(i) [*26 USCS § 410(b)(2)(A)(i)*] (determined by applying the rules of paragraph (1)(I)),

(iii)after the date as of which the class was closed, any plan amendment to the defined contribution plan which modifies the closed class or the allocations, benefits, rights, and features provided to such closed class does not discriminate significantly in favor of highly compensated employees, and

(iv)the class was closed before April 5, 2017, or the defined benefit plan under clause (i) is described in paragraph (1)(C) (as applied for purposes of paragraph (1)(B)(iii)(IV)).

(B) Aggregation with plans including matching contributions.

(i) In general. With respect to 1 or more defined contribution plans described in subparagraph (A), for purposes of determining compliance with subsection (a)(4) and section 410(b) [*26 USCS § 410(b)*], the portion of such plans which provides make-whole contributions or other nonelective contributions may be aggregated and tested on a benefits basis with the portion of 1 or more other defined contribution plans which—

(I)provides matching contributions (as defined in subsection (m)(4)(A)),

(II)provides annuity contracts described in section 403(b) [*26 USCS § 403(b)*] which are purchased with matching contributions or nonelective contributions, or

(III)consists of an employee stock ownership plan (within the meaning of section 4975(e)(7) [*26 USCS § 4975(e)(7)*]) or a tax credit employee stock ownership plan (within the meaning of section 409(a) [*26 USCS § 409(a)*]).

(ii) Special rules for matching contributions. Rules similar to the rules of paragraph (1)(B)(ii) shall apply for purposes of clause (i).

(C) Special rules for testing defined contribution plan features providing matching contributions to certain older, longer service participants. In the case of a defined contribution plan which provides benefits, rights, or features to a closed class of participants whose accruals under a defined benefit plan have been reduced or eliminated, the plan shall not fail to satisfy the requirements of subsection (a)(4) solely by reason of the composition of the closed class or the benefits, rights, or features provided to such closed class if the defined contribution plan and defined benefit plan otherwise meet the requirements of subparagraph (A) but for the fact that the make-whole contributions under the defined contribution plan are made in whole or in part through matching contributions.

(D) Spun-off plans. For purposes of this paragraph, if a portion of a defined contribution plan described in subparagraph (A) or (C) is spun off to another employer, the treatment under subparagraph (A) or (C) of the spun-off plan shall continue with respect to the other employer if such plan continues to comply with the requirements of clauses (ii) (if the original plan was still within the 3-year period described in such clause at the time of the spin off) and (iii) of subparagraph (A), as determined for purposes of subparagraph (A) or (C), whichever is applicable.

(3) Definitions and special rule. For purposes of this subsection—

(A) Make-whole contributions. Except as otherwise provided in paragraph (2)(C), the term "make-whole contributions" means nonelective allocations for each employee in the class which are reasonably calculated, in a consistent manner, to replace some or all of the retirement benefits which the employee would have received under the defined benefit plan and any other plan or qualified cash or deferred arrangement under subsection (k)(2) if no change had been made to such defined benefit plan and such other plan or arrangement. For purposes of the preceding sentence, consistency shall not be required with respect to employees who were subject to different benefit formulas under the defined benefit plan.

(B) References to closed class of participants. References to a closed class of participants and similar references to a closed class shall include arrangements under which 1 or more classes of participants are closed, except that 1 or more classes of participants closed on different dates shall not be aggregated for purposes of determining the date any such class was closed.

(C) Highly compensated employee. The term "highly compensated employee" has the meaning given such term in section 414(q) [*26 USCS § 414(q)*].

(p) Cross reference. For exemption from tax of a trust qualified under this section, see section 501(a) [*26 USCS § 501(a)*].

History

HISTORY:

Act *Aug. 16, 1954, ch 736*, 68A Stat. 134; Oct. 10, 1962, *P. L. 87-792*, § 2, *76 Stat. 809*; Oct. 23, 1962, *P. L. 87-863*, § 2(a), *76 Stat. 1141*; Feb. 26, 1964, *P. L. 88-272*, Title II, § 219(a), *78 Stat. 57*; July 30, 1965, *P. L. 89-97*, Title I, § 106(d)(4), *79 Stat. 337*; Nov. 13, 1966, *P. L. 89-809*, Title II, §§ 204(b)(1), (c), 205(a), *80 Stat. 1577*, 1578; Jan. 12, 1971, *P. L. 91-691*, § 1(a), *84 Stat. 2074*; Sept. 2, 1974, *P. L. 93-406*, Title II, §§ 1012(b), 1016(a)(2), 1021, 1022(a)–(d), (f), 1023, 2001(c)–(e)(4), (h)(1), 2004(a)(1), *88 Stat. 913*, 929, 935, 938-940, 943, 952-955, 957, 979; April 15, 1976, *P. L. 94-267*, § 1(c)(1), (2), *90 Stat. 367*; Oct. 4, 1976, *P. L. 94-455*, Title VIII, § 803(b)(2), Title XV, § 1505(b), Title XIX, §§ 1901(a)(56), 1906(b)(13)(A), *90 Stat. 1584*, 1738, 1773, 1834; Nov. 6, 1978, *P. L. 95-600*, Title I, §§ 135(a), 141(f)(3), 143(a), 152(e), *92 Stat. 2785*, 2795, 2796, 2799; April 1, 1980, *P. L. 96-222*, Title I, § 101(a)(7)(L)(i)(V), (9), (14)(E)(iii), *94 Stat. 199*, 201, 205; Sept. 26, 1980, *P. L. 96-364*, Title II, § 208(a), (e), Title IV, § 410(b), *94 Stat. 1289*, 1290, 1308; Dec. 28, 1980, *P. L. 96-605*, Title II, §§ 221(a), 225(b)(1), (2), *94 Stat. 3528*, 3529; Aug. 13, 1981, *P. L. 97-34*, Title III, §§ 312(b)(1), (c)(2)–(4), (e)(2), 314(a)(1), 335, 338(a), *95 Stat. 283*-286, 297, 298; Sept. 3, 1982, *P. L. 97-248*, Title II, §§ 237(a), (b), (e)(1), 238(b), (d)(1), (2), 240(b), 242(a), 249(a), 254(a), *96 Stat. 511*-513, 520, 521, 527, 533; Jan. 12, 1983, *P. L. 97-448*, Title I, § 103(c)(10)(A), (d)(2), (g)(2)(A), Title III, § 306(a)(12), *96 Stat. 2377*-2379, 2405; April 20, 1983, *P. L. 98-21*, Title I, § 124(c)(4)(A), *97 Stat. 91*; July 18, 1984, *P. 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§ 1056. Form and payment of benefits

(a) Commencement date for payment of benefits. Each pension plan shall provide that unless the participant otherwise elects, the payment of benefits under the plan to the participant shall begin not later than the 60th day after the latest of the close of the plan year in which—

(1) occurs the date on which the participant attains the earlier of age 65 or the normal retirement age specified under the plan,

(2) occurs the 10th anniversary of the year in which the participant commenced participation in the plan, or

(3) the participant terminates his service with the employer.

In the case of a plan which provides for the payment of an early retirement benefit, such plan shall provide that a participant who satisfied the service requirements for such early retirement benefit, but separated from the service (with any nonforfeitable right to an accrued benefit) before satisfying the age requirement for such early retirement benefit, is entitled upon satisfaction of such age requirement to receive a benefit not less than the benefit to which he would be entitled at the normal retirement age, actuarially reduced under regulations prescribed by the Secretary of the Treasury.

(b) Decrease in plan benefits by reason of increases in benefit levels under Social Security Act or Railroad Retirement Act of 1937. If—

(1) a participant or beneficiary is receiving benefits under a pension plan, or

(2) a participant is separated from the service and has nonforfeitable rights to benefits,

a plan may not decrease benefits of such a participant by reason of any increase in the benefit levels payable under title II of the Social Security Act [*42 USCS §§ 401* et seq.] or the Railroad Retirement Act of 1937, or any increase in the wage base under such title II [*42 USCS §§ 401* et seq.], if such increase takes place after the date of the enactment of this Act [enacted Sept. 2, 1974] or (if later) the earlier of the date of first entitlement of such benefits or the date of such separation.

(c) Forfeitures of accrued benefits derived from employer contributions. No pension plan may provide that any part of a participant's accrued benefit derived from employer contributions (whether or not otherwise nonforfeitable) is forfeitable solely because of withdrawal by such participant of any amount attributable to the benefit derived from contributions made by such participant. The preceding sentence shall not apply (1) to the accrued benefit of any participant unless, at the time of such

withdrawal, such participant has a nonforfeitable right to at least 50 percent of such accrued benefit, or (2) to the extent that an accrued benefit is permitted to be forfeited in accordance with section 203(a)(3)(D)(iii) [*29 USCS § 1053(a)(3)(D)(iii)*].

(d) Assignment or alienation of plan benefits.

(1) Each pension plan shall provide that benefits provided under the plan may not be assigned or alienated.

(2) For the purposes of paragraph (1) of this subsection, there shall not be taken into account any voluntary and revocable assignment of not to exceed 10 percent of any benefit payment, or of any irrevocable assignment or alienation of benefits executed before the date of enactment of this Act [enacted Sept. 2, 1974]. The preceding sentence shall not apply to any assignment or alienation made for the purposes of defraying plan administration costs. For purposes of this paragraph a loan made to a participant or beneficiary shall not be treated as an assignment or alienation if such loan is secured by the participant's accrued nonforfeitable benefit and is exempt from the tax imposed by *section 4975 of the Internal Revenue Code of 1986* [*26 USCS § 4975*] (relating to tax on prohibited transactions) by reason of section 4975(d)(1) of such Code [*26 USCS § 4975(d)(1)*].

(3)

(A) Paragraph (1) shall apply to the creation, assignment, or recognition of a right to any benefit payable with respect to a participant pursuant to a domestic relations order, except that paragraph (1) shall not apply if the order is determined to be a qualified domestic relations order. Each pension plan shall provide for the payment of benefits in accordance with the applicable requirements of any qualified domestic relations order.

(B) For purposes of this paragraph—

(i)the term "qualified domestic relations order" means a domestic relations order—

(I)which creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under a plan, and

(II)with respect to which the requirements of subparagraphs (C) and (D) are met, and

(ii)the term "domestic relations order" means any judgment, decree, or order (including approval of a property settlement agreement) which—

(I)relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant, and

(II)is made pursuant to a State domestic relations law (including a community property law).

(C)A domestic relations order meets the requirements of this subparagraph only if such order clearly specifies—

(i)the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate payee covered by the order,

(ii)the amount or percentage of the participant's benefits to be paid by the plan to each such alternate payee, or the manner in which such amount or percentage is to be determined.

(iii)the number of payments or period to which such order applies, and

(iv)each plan to which such order applies.

(D)A domestic relations order meets the requirements of this subparagraph only if such order—

(i)does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan,

(ii)does not require the plan to provide increased benefits (determined on the basis of actuarial value), and

(iii)does not require the payment of benefits to an alternate payee which are required to be paid to another alternate payee under another order previously determined to be a qualified domestic relations order.

(E)

(i)A domestic relations order shall not be treated as failing to meet the requirements of clause (i) of subparagraph (D) solely because such order requires that payment of benefits be made to an alternate payee—

(I)on or in the case of any payment before a participant has separated from service, after the date on which the participant attains (or would have attained) the earliest retirement age,

(II)as if the participant had retired on the date on which such payment is to begin under such order (but taking into account only the present value of benefits actually accrued and not taking into account the present value of any employer subsidy for early retirement), and

(III)in any form in which such benefits may be paid under the plan to the participant (other than in the form of a joint and survivor annuity with respect to the alternate payee and his or her subsequent spouse).

For purposes of subclause (II), the interest rate assumption used in determining the present value shall be the interest rate specified in the plan or, if no rate is specified, 5 percent.

(ii) For purposes of this subparagraph, the term "earliest retirement age" means the earlier of—

(I)the date on which the participant is entitled to a distribution under the plan, or

(II)the later of the date of the participant attains age 50 or the earliest date on which the participant could begin receiving benefits under the plan if the participant separated from service.

(F) To the extent provided in any qualified domestic relations order—

(i)the former spouse of a participant shall be treated as a surviving spouse of such participant for purposes of section 205 [*29 USCS § 1055*] (and any spouse of the participant shall not be treated as a spouse of the participant for such purposes), and

(ii)if married for at least 1 year, the surviving former spouse shall be treated as meeting the requirements of section 205(f) [*29 USCS § 1055(f)*].

(G)

(i) In the case of any domestic relations order received by a plan—

(I)the plan administrator shall promptly notify the participant and each alternate payee of the receipt of such order and the plan's procedures for determining the qualified status of domestic relations orders, and

(II)within a reasonable period after receipt of such order, the plan administrator shall determine whether such order is a qualified domestic relations order and notify the participant and each alternate payee of such determination.

(ii) Each plan shall establish reasonable procedures to determine the qualified status of domestic relations orders and to administer distributions under such qualified orders. Such procedures—

(I)shall be in writing,

(II)shall provide for the notification of each person specified in a domestic relations order as entitled to payment of benefits under the plan (at the address included in the domestic relations order) of such procedures promptly upon receipt by the plan of the domestic relations order, and

(III)shall permit an alternate payee to designate a representative for receipt of copies of notices that are sent to the alternate payee with respect to a domestic relations order.

(H)

(i) During any period in which the issue of whether a domestic relations order is a qualified domestic relations order is being determined (by the plan administrator, by a court of competent jurisdiction, or otherwise), the plan administrator shall separately account for the amounts (hereinafter in this subparagraph referred to as the "segregated amounts") which would have been payable to the alternate payee during such period if the order had been determined to be a qualified domestic relations order.

(ii) If within the 18-month period described in clause (v) the order (or modification thereof) is determined to be a qualified domestic relations order, the plan administrator shall pay the segregated amounts (including any interest thereon) to the person or persons entitled thereto.

(iii) If within the 18-month period described in clause (v)—

(I)it is determined that the order is not a qualified domestic relations order, or

(II)the issue as to whether such order is a qualified domestic relations order is not resolved,

then the plan administrator shall pay the segregated amounts (including any interest thereon) to the person or persons who would have been entitled to such amounts if there had been no order.

(iv) Any determination that an order is a qualified domestic relations order which is made after the close of the 18-month period described in clause (v) shall be applied prospectively only.

(v) For purposes of this subparagraph, the 18-month period described in this clause is the 18-month period beginning with the date on which the first payment would be required to be made under the domestic relations order.

(I) If a plan fiduciary acts in accordance with part 4 of this subtitle [*29 USCS §§ 1101* et seq.] in—

(i)treating a domestic relations order as being (or not being) a qualified domestic relations order, or

(ii)taking action under subparagraph (H),

then the plan's obligation to the participant and each alternate payee shall be discharged to the extent of any payment made pursuant to such Act.

(J)A person who is an alternate payee under a qualified domestic relations order shall be considered for purposes of any provision of this Act a beneficiary under the plan. Nothing in the preceding sentence shall permit a requirement under section 4001 [*29 USCS § 1301*] of the payment of more than 1 premium with respect to a participant for any period.

(K) The term "alternate payee" means any spouse, former spouse, child, or other dependent of a participant who is recognized by a domestic relations order as having a right to receive all, or a portion of, the benefits payable under a plan with respect to such participant.

(L) This paragraph shall not apply to any plan to which paragraph (1) does not apply.

(M) Payment of benefits by a pension plan in accordance with the applicable requirements of a qualified domestic relations order shall not be treated as garnishment for purposes of section 303(a) of the Consumer Credit Protection Act [*15 USCS § 1673(a)*].

(N) In prescribing regulations under this paragraph, the Secretary shall consult with the Secretary of the Treasury.

(4) Paragraph (1) shall not apply to any offset of a participant's benefits provided under an employee pension benefit plan against an amount that the participant is ordered or required to pay to the plan if—

(A)the order or requirement to pay arises—

(i)under a judgment of conviction for a crime involving such plan,

(ii)under a civil judgment (including a consent order or decree) entered by a court in an action brought in connection with a violation (or alleged violation) of part 4 of this subtitle [*29 USCS §§ 1101* et seq.], or

(iii)pursuant to a settlement agreement between the Secretary and the participant, or a settlement agreement between the Pension Benefit Guaranty Corporation and the

participant, in connection with a violation (or alleged violation) of part 4 of this subtitle [*29 USCS §§ 1101* et seq.] by a fiduciary or any other person,

(B)the judgment, order, decree, or settlement agreement expressly provides for the offset of all or part of the amount ordered or required to be paid to the plan against the participant's benefits provided under the plan, and

(C)in a case in which the survivor annuity requirements of section 205 [*29 USCS § 1055*] apply with respect to distributions from the plan to the participant, if the participant has a spouse at the time at which the offset is to be made—

(i)either—

(I)such spouse has consented in writing to such offset and such consent is witnessed by a notary public or representative of the plan (or it is established to the satisfaction of a plan representative that such consent may not be obtained by reason of circumstances described in section 205(c)(2)(B) [*29 USCS § 1055(c)(2)(B)*]), or

(II)an election to waive the right of the spouse to a qualified joint and survivor annuity or a qualified preretirement survivor annuity is in effect in accordance with the requirements of section 205(c) [*29 USCS § 1055(c)*],

(ii)such spouse is ordered or required in such judgment, order, decree, or settlement to pay an amount to the plan in connection with a violation of part 4 of this subtitle [*29 USCS §§ 1101* et seq.], or

(iii)in such judgment, order, decree, or settlement, such spouse retains the right to receive the survivor annuity under a qualified joint and survivor annuity provided pursuant to section 205(a)(1) [*29 USCS § 1055(a)(1)*] and under a qualified preretirement survivor annuity provided pursuant to section 205(a)(2) [*29 USCS § 1055(a)(2)*], determined in accordance with paragraph (5).

A plan shall not be treated as failing to meet the requirements of section 205 [*29 USCS § 1055*] solely by reason of an offset under this paragraph.

(5)

(A) The survivor annuity described in paragraph (4)(C)(iii) shall be determined as if—

(i)the participant terminated employment on the date of the offset,

(ii)there was no offset,

(iii)the plan permitted commencement of benefits only on or after normal retirement age,

(iv)the plan provided only the minimum-required qualified joint and survivor annuity, and

(v)the amount of the qualified preretirement survivor annuity under the plan is equal to the amount of the survivor annuity payable under the minimum-required qualified joint and survivor annuity.

(B) For purposes of this paragraph, the term "minimum-required qualified joint and survivor annuity" means the qualified joint and survivor annuity which is the actuarial equivalent of the participant's accrued benefit (within the meaning of section 3(23) [*29 USCS § 1002(23)*]) and under which the survivor annuity is 50 percent of the amount of the annuity which is payable during the joint lives of the participant and the spouse.

(e) Limitation on distributions other than life annuities paid by plan.

(1) In general. Notwithstanding any other provision of this part, the fiduciary of a pension plan that is subject to the additional funding requirements of section 303(j)(4) [*29 USCS § 1083(j)(4)*] shall not permit a prohibited payment to be made from a plan during a period in which such plan has a liquidity shortfall (as defined in section 303(j)(4)(E)(i) [*29 USCS § 1083(j)(4)(E)(i)*]).

(2) Prohibited payment. For purposes of paragraph (1), the term "prohibited payment" means—

(A)any payment, in excess of the monthly amount paid under a single life annuity (plus any social security supplements described in the last sentence of section 204(b)(1)(G) [*29 USCS § 1054(b)(1)(G)*]), to a participant or beneficiary whose annuity starting date (as defined in section 205(h)(2) [*29 USCS § 1055(h)(2)*]), that occurs during the period referred to in paragraph (1),

(B)any payment for the purchase of an irrevocable commitment from an insurer to pay benefits, and

(C)any other payment specified by the Secretary of the Treasury by regulations.

(3) Period of shortfall. For purposes of this subsection, a plan has a liquidity shortfall during the period that there is an underpayment of an installment under section 303(j)(3) [*29 USCS § 1083(j)(3)*] by reason of section 303(j)(4)(A) [*29 USCS § 1083(j)(4)(A)*].

(4) Coordination with other provisions. Compliance with this subsection shall not constitute a violation of any other provision of this Act.

(f) Missing participants in terminated plans. In the case of a plan covered by section 4050 [*29 USCS § 1350*], upon termination of the plan, benefits of missing participants shall be treated in accordance with section 4050 [*29 USCS § 1350*].

(g) Funding-based limits on benefits and benefit accruals under single-employer plans.

(1) Funding-based limitation on shutdown benefits and other unpredictable contingent event benefits under single-employer plans.

(A) In general. If a participant of a defined benefit plan which is a single-employer plan is entitled to an unpredictable contingent event benefit payable with respect to any event occurring during any plan year, the plan shall provide that such benefit may not be provided if the adjusted funding target attainment percentage for such plan year—

(i)is less than 60 percent, or

(ii)would be less than 60 percent taking into account such occurrence.

(B) Exemption. Subparagraph (A) shall cease to apply with respect to any plan year, effective as of the first day of the plan year, upon payment by the plan sponsor of a

contribution (in addition to any minimum required contribution under section 303 [*29 USCS § 1083*]) equal to—

(i)in the case of subparagraph (A)(i), the amount of the increase in the funding target of the plan (under section 303 [*29 USCS § 1083*]) for the plan year attributable to the occurrence referred to in subparagraph (A), and

(ii)in the case of subparagraph (A)(ii), the amount sufficient to result in an adjusted funding target attainment percentage of 60 percent.

(C) Unpredictable contingent event benefit. For purposes of this paragraph, the term "unpredictable contingent event benefit" means any benefit payable solely by reason of—

(i)a plant shutdown (or similar event, as determined by the Secretary of the Treasury), or

(ii)an event other than the attainment of any age, performance of any service, receipt or derivation of any compensation, or occurrence of death or disability.

(2) Limitations on plan amendments increasing liability for benefits.

(A) In general. No amendment to a defined benefit plan which is a single-employer plan which has the effect of increasing liabilities of the plan by reason of increases in benefits, establishment of new benefits, changing the rate of benefit accrual, or changing the rate at which benefits become nonforfeitable may take effect during any plan year if the adjusted funding target attainment percentage for such plan year is—

(i)less than 80 percent, or

(ii)would be less than 80 percent taking into account such amendment.

(B) Exemption. Subparagraph (A) shall cease to apply with respect to any plan year, effective as of the first day of the plan year (or if later, the effective date of the amendment), upon payment by the plan sponsor of a contribution (in addition to any minimum required contribution under section 303 [*29 USCS § 1083*]) equal to—

(i)in the case of subparagraph (A)(i), the amount of the increase in the funding target of the plan (under section 303 [*29 USCS § 1083*]) for the plan year attributable to the amendment, and

(ii)in the case of subparagraph (A)(ii), the amount sufficient to result in an adjusted funding target attainment percentage of 80 percent.

(C) Exception for certain benefit increases. Subparagraph (A) shall not apply to any amendment which provides for an increase in benefits under a formula which is not based on a participant's compensation, but only if the rate of such increase is not in excess of the contemporaneous rate of increase in average wages of participants covered by the amendment.

(3) Limitations on accelerated benefit distributions.

(A) Funding percentage less than 60 percent. A defined benefit plan which is a single-employer plan shall provide that, in any case in which the plan's adjusted funding target attainment percentage for a plan year is less than 60 percent, the plan may not pay any prohibited payment after the valuation date for the plan year.

(B) Bankruptcy. A defined benefit plan which is a single-employer plan shall provide that, during any period in which the plan sponsor is a debtor in a case under title 11, United States Code, or similar Federal or State law, the plan may not pay any prohibited payment. The preceding sentence shall not apply on or after the date on which the enrolled actuary of the plan certifies that the adjusted funding target attainment percentage of such plan (determined by not taking into account any adjustment of segment rates under section 303(h)(2)(C)(iv) [*29 USCS § 1083(h)(2)(C)(iv)*]) is not less than 100 percent.

(C) Limited payment if percentage at least 60 percent but less than 80 percent.

(i) In general. A defined benefit plan which is a single-employer plan shall provide that, in any case in which the plan's adjusted funding target attainment percentage for a plan year is 60 percent or greater but less than 80 percent, the plan may not pay any prohibited payment after the valuation date for the plan year to the extent the amount of the payment exceeds the lesser of—

(I)50 percent of the amount of the payment which could be made without regard to this subsection, or

(II)the present value (determined under guidance prescribed by the Pension Benefit Guaranty Corporation, using the interest and mortality assumptions under section 205(g) [*29 USCS § 1055(g)*]) of the maximum guarantee with respect to the participant under section 4022 [*29 USCS § 1322*].

(ii) One-time application.

(I) In general. The plan shall also provide that only 1 prohibited payment meeting the requirements of clause (i) may be made with respect to any participant during any period of consecutive plan years to which the limitations under either subparagraph (A) or (B) or this subparagraph applies.

(II) Treatment of beneficiaries. For purposes of this clause, a participant and any beneficiary on his behalf (including an alternate payee, as defined in section 206(d)(3)(K) [subsec. (d)(3)(K) of this section]) shall be treated as 1 participant. If the accrued benefit of a participant is allocated to such an alternate payee and 1 or more other persons, the amount under clause (i) shall be allocated among such persons in the same manner as the accrued benefit is allocated unless the qualified domestic relations order (as defined in section 206(d)(3)(B)(i) [subsec. (d)(3)(B)(i) of this section]) provides otherwise.

(D) Exception. This paragraph shall not apply to any plan for any plan year if the terms of such plan (as in effect for the period beginning on September 1, 2005, and ending with such plan year) provide for no benefit accruals with respect to any participant during such period.

(E) Prohibited payment. For purpose of this paragraph, the term "prohibited payment" means—

(i)any payment, in excess of the monthly amount paid under a single life annuity (plus any social security supplements described in the last sentence of section 204(b)(1)(G) [*29 USCS § 1054(b)(1)(G)*]), to a participant or beneficiary whose annuity starting date

(as defined in section 205(h)(2) [*29 USCS § 1055(h)(2)*]) occurs during any period a limitation under subparagraph (A) or (B) is in effect,

(ii)any payment for the purchase of an irrevocable commitment from an insurer to pay benefits, and

(iii)any other payment specified by the Secretary of the Treasury by regulations.

Such term shall not include the payment of a benefit which under section 203(e) [*29 USCS § 1053(e)*] may be immediately distributed without the consent of the participant.

(4) Limitation on benefit accruals for plans with severe funding shortfalls.

(A) In general. A defined benefit plan which is a single-employer plan shall provide that, in any case in which the plan's adjusted funding target attainment percentage for a plan year is less than 60 percent, benefit accruals under the plan shall cease as of the valuation date for the plan year.

(B) Exemption. Subparagraph (A) shall cease to apply with respect to any plan year, effective as of the first day of the plan year, upon payment by the plan sponsor of a contribution (in addition to any minimum required contribution under section 303 [*29 USCS § 1083*]) equal to the amount sufficient to result in an adjusted funding target attainment percentage of 60 percent.

(5) Rules relating to contributions required to avoid benefit limitations.

(A) Security may be provided.

(i) In general. For purposes of this subsection, the adjusted funding target attainment percentage shall be determined by treating as an asset of the plan any security provided by a plan sponsor in a form meeting the requirements of clause (ii).

(ii) Form of security. The security required under clause (i) shall consist of—

(I)a bond issued by a corporate surety company that is an acceptable surety for purposes of section 412 of this Act [*29 USCS § 1112*],

(II)cash, or United States obligations which mature in 3 years or less, held in escrow by a bank or similar financial institution, or

(III)such other form of security as is satisfactory to the Secretary of the Treasury and the parties involved.

(iii) Enforcement. Any security provided under clause (i) may be perfected and enforced at any time after the earlier of—

(I)the date on which the plan terminates,

(II)if there is a failure to make a payment of the minimum required contribution for any plan year beginning after the security is provided, the due date for the payment under section 303(j) [*29 USCS § 1083(j)*], or

(III)if the adjusted funding target attainment percentage is less than 60 percent for a consecutive period of 7 years, the valuation date for the last year in the period.

(iv) Release of security. The security shall be released (and any amounts thereunder shall be refunded together with any interest accrued thereon) at such time as the Secretary of the Treasury may prescribe in regulations, including regulations for partial releases of the security by reason of increases in the adjusted funding target attainment percentage.

(B) Prefunding balance or funding standard carryover balance may not be used. No prefunding balance or funding standard carryover balance under section 303(f) [*29 USCS § 1083(f)*] may be used under paragraph (1), (2), or (4) to satisfy any payment an employer may make under any such paragraph to avoid or terminate the application of any limitation under such paragraph.

(C) Deemed reduction of funding balances.

(i) In general. Subject to clause (iii), in any case in which a benefit limitation under paragraph (1), (2), (3), or (4) would (but for this subparagraph and determined without regard to paragraph (1)(B), (2)(B), or (4)(B)) apply to such plan for the plan year, the plan sponsor of such plan shall be treated for purposes of this Act as having made an election under section 303(f) [*29 USCS § 1083(f)*]to reduce the prefunding balance or funding standard carryover balance by such amount as is necessary for such benefit limitation to not apply to the plan for such plan year.

(ii) Exception for insufficient funding balances. Clause (i) shall not apply with respect to a benefit limitation for any plan year if the application of clause (i) would not result in the benefit limitation not applying for such plan year.

(iii) Restrictions of certain rules to collectively bargained plans. With respect to any benefit limitation under paragraph (1), (2), or (4), clause (i) shall only apply in the case of a plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers.

(6) New plans. Paragraphs (1), (2), and (4) shall not apply to a plan for the first 5 plan years of the plan. For purposes of this paragraph, the reference in this paragraph to a plan shall include a reference to any predecessor plan.

(7) Presumed underfunding for purposes of benefit limitations.

(A) Presumption of continued underfunding. In any case in which a benefit limitation under paragraph (1), (2), (3), or (4) has been applied to a plan with respect to the plan year preceding the current plan year, the adjusted funding target attainment percentage of the plan for the current plan year shall be presumed to be equal to the adjusted funding target attainment percentage of the plan for the preceding plan year until the enrolled actuary of the plan certifies the actual adjusted funding target attainment percentage of the plan for the current plan year.

(B) Presumption of underfunding after 10th month. In any case in which no certification of the adjusted funding target attainment percentage for the current plan year is made with respect to the plan before the first day of the 10th month of such year, for purposes of paragraphs (1), (2), (3), and (4), such first day shall be deemed, for purposes of such paragraph, to be the valuation date of the plan for the current plan year and the plan's

adjusted funding target attainment percentage shall be conclusively presumed to be less than 60 percent as of such first day.

(C) Presumption of underfunding after 4th month for nearly underfunded plans. In any case in which—

(i)a benefit limitation under paragraph (1), (2), (3), or (4) did not apply to a plan with respect to the plan year preceding the current plan year, but the adjusted funding target attainment percentage of the plan for such preceding plan year was not more than 10 percentage points greater than the percentage which would have caused such paragraph to apply to the plan with respect to such preceding plan year, and

(ii)as of the first day of the 4th month of the current plan year, the enrolled actuary of the plan has not certified the actual adjusted funding target attainment percentage of the plan for the current plan year,

until the enrolled actuary so certifies, such first day shall be deemed, for purposes of such paragraph, to be the valuation date of the plan for the current plan year and the adjusted funding target attainment percentage of the plan as of such first day shall, for purposes of such paragraph, be presumed to be equal to 10 percentage points less than the adjusted funding target attainment percentage of the plan for such preceding plan year.

(8) Treatment of plan as of close of prohibited or cessation period. For purposes of applying this part—

(A) Operation of plan after period. Unless the plan provides otherwise, payments and accruals will resume effective as of the day following the close of the period for which any limitation of payment or accrual of benefits under paragraph (3) or (4) applies.

(B) Treatment of affected benefits. Nothing in this paragraph shall be construed as affecting the plan's treatment of benefits which would have been paid or accrued but for this subsection.

(9) Terms relating to funding target attainment percentage. For purposes of this subsection—

(A) In general. The term "funding target attainment percentage" has the same meaning given such term by section 303(d)(2) [*29 USCS § 1083(d)(2)*].

(B) Adjusted funding target attainment percentage. The term "adjusted funding target attainment percentage" means the funding target attainment percentage which is determined under subparagraph (A) by increasing each of the amounts under subparagraphs (A) and (B) of section 303(d)(2) [*29 USCS § 1083(d)(2)*] by the aggregate amount of purchases of annuities for employees other than highly compensated employees (as defined in *section 414(q) of the Internal Revenue Code of 1986* [*26 USCS § 414(q)*]) which were made by the plan during the preceding 2 plan years.

(C) Application to plans which are fully funded without regard to reductions for funding balances. In the case of a plan for any plan year, if the funding target attainment percentage is 100 percent or more (determined without regard to the reduction in the value of assets under section 303(f)(4) [*29 USCS § 1083(f)(4)*]), the funding target attainment percentage for purposes of subparagraphs (A) and (B) shall be determined without regard to such reduction.

(D)[Deleted]

(10) Secretarial authority for plans with alternate valuation date. In the case of a plan which has designated a valuation date other than the first day of the plan year, the Secretary of the Treasury may prescribe rules for the application of this subsection which are necessary to reflect the alternate valuation date.

(11)[Deleted]

(12)CSEC plans. This subsection shall not apply to a CSEC plan (as defined in section 210(f) [*29 USCS § 1060(f)*]).

History

HISTORY:

Act Sept. 2, 1974, *P. L. 93-406*, Title I, Subtitle B, Part 2, § 206, *88 Stat. 864*; Aug. 23, 1984, *P. L. 98-397*, Title I, § 104(a), *98 Stat. 1433*; Oct. 22, 1986, *P. L. 99-514*, Title XVIII, Subtitle C, Ch 2, § 1898(c)(2)(B), (4)(B), (5), (6)(B), (7)(B), *100 Stat. 2952*–2954; Dec. 19, 1989, *P. L. 101-239*, Title VII, Subtitle G, Part V, Subpart D, §§ 7891(a)(1), 7894(c)(8), (9)(A), *103 Stat. 2445*, 2449; Dec. 8, 1994, *P. L. 103-465*, Title VII, Subtitle F, Part I, Subpart B, § 761(a)(9)(B)(i), Part II, § 776(c)(2), *108 Stat. 5033*, 5048; Aug. 5, 1997, *P. L. 105-34*, Title XV, Subtitle A, § 1502(a), *111 Stat. 1058*; Aug. 17, 2006, *P. L. 109-280*, Title I, Subtitle A, §§ 103(a), 108(a)(9), (10) [107(a)(9), (10)], Title IV, § 410(b), *120 Stat. 809*, 819, 935; Dec. 23, 2008, *P. L. 110-458*, Title I, Subtitle A, § 101(c)(1)(B)–(G), *122 Stat. 5097*; June 25, 2010, *P. L. 111-192*, Title II, Subtitle A, §§ 202(a), 203(a)(1), *124 Stat. 1297*, 1299; April 7, 2014, *P. L. 113-97*, Title I, § 102(b)(3), *128 Stat. 1116*; Aug. 8, 2014, *P. L. 113-159*, Title II, § 2003(c)(2), *128 Stat. 1850*; Dec. 19, 2014, *P. L. 113-295*, Div A, Title II, § 221(a)(57)(E)(ii), (F)(ii), (G)(ii), *128 Stat. 4046*, 4047.

End of Document

Retirement Equity Act of 1984., 98 Stat. 1426

Enacted, August 23, 1984

Reporter
98 P.L. 397; 98 Stat. 1426

United States Statutes at Large > 98th Congress, 2nd Session > Public Law 98-397

Synopsis

AN ACT

To amend the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1954 to improve the delivery of retirement benefits and provide for greater equity under private pension plans for workers and their spouses and dependents by taking into account changes in work patterns, the status of marriage as an economic partnership, and the substantial contribution to that partnership of spouses who work both in and outside the home, and for other purposes.

Text

CIS Legis. History:*98 CIS Legis. Hist. P.L. 397*

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History

Legislative History:
- H.R. 4280

HOUSE REPORTS: No. 98-655, Pt. 1 (Comm. on Education and Labor) and Pt. 2 (Comm. on Ways and Means).

SENATE REPORT No. 98-575 (Comm. on Finance).

CONGRESSIONAL RECORD, Vol. 130 (1984):

May 22, considered and passed House.

Aug. 6, considered and passed Senate, amended.

Aug. 9, House concurred in Senate amendment.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 20, No. 35 (1984):

Aug. 23, Presidential statement.

United States Statutes at Large

End of Document

Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan

Supreme Court of the United States

October 7, 2008, Argued; January 26, 2009, Decided

No. 07-636

Reporter
555 U.S. 285 *; 129 S. Ct. 865 **; 172 L. Ed. 2d 662 ***; 2009 U.S. LEXIS 869 ****; 77 U.S.L.W. 4082; 2009-1 U.S. Tax Cas. (CCH) P50,383; 45 Employee Benefits Cas. (BNA) 2249; 21 Fla. L. Weekly Fed. S 622

KARI E. KENNEDY, executrix of the ESTATE OF WILLIAM PATRICK KENNEDY, DECEASED, Petitioner v. PLAN ADMINISTRATOR FOR DuPONT SAVINGS AND INVESTMENT PLAN, et al.

Prior History: [**1]** ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT.

Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 497 F.3d 426, 2007 U.S. App. LEXIS 19336 (5th Cir. Tex., 2007)

Disposition: *497 F.3d 426*, affirmed.

Syllabus

[*285] [866]** The Employee Retirement Income Security Act of 1974 (ERISA), as relevant here, obligates administrators to manage ERISA plans "in accordance with the documents and instruments governing" them, *29 U.S.C. § 1104(a)(1)(D)*; requires covered pension benefit plans to "provide that benefits . . . may not be assigned or alienated," *§ 1056(d)(1)*; and exempts from this bar qualified domestic relations orders (QDROs), *§ 1056(d)(3)*. The decedent, William Kennedy, participated in his employer's savings and investment plan (SIP), with power both to designate a beneficiary to receive the funds upon his death and to replace or revoke that designation as prescribed by the plan administrator. Under the terms of the plan, if there is no surviving spouse or designated beneficiary at the time of death, distribution is made as directed by the estate's executor or administrator. Upon their marriage, William designated Liv Kennedy his SIP beneficiary and named no contingent beneficiary. Their subsequent divorce decree divested Liv of her interest in the SIP benefits, but William did not execute a document **[****2]** removing Liv as the SIP beneficiary. On William's death, petitioner Kari Kennedy, his daughter and the executrix of his Estate, asked for the SIP funds to be distributed to the Estate, but the plan

administrator relied on William's designation form and paid them to Liv. The Estate filed suit, alleging that Liv had waived her SIP benefits in the divorce and thus respondents, the employer and the SIP plan administrator (together, DuPont), had violated ERISA by paying her. As relevant here, the District Court entered summary judgment for the Estate, ordering DuPont to pay the benefits to the Estate. The Fifth Circuit reversed, holding that Liv's waiver was an assignment or alienation of her interest to the Estate barred by *§ 1056(d)(1)*.

Held:

1. Because Liv did not attempt to direct her interest in the SIP benefits to the Estate or any other potential beneficiary, her waiver did not constitute an assignment or alienation rendered void under *§ 1056(d)(1)*. Pp. 292-299.

[*286] (a) Given the legal meaning of "assigned" and "alienated," it is fair to say that Liv did not assign or alienate anything to William or to the Estate. The Fifth Circuit's broad reading--that Liv's waiver indirectly transferred **[****3]** her interest to the next possible beneficiary, here the Estate--is questionable. It would be odd to speak of an estate as the transferee of its own decedent's property or of the decedent in his lifetime as his own transferee. It would also be strange under the Treasury regulation that defines "assignment" and "alienation." Moreover, it is difficult to see how certain waivers not barred by the antialienation provision, *e.g.*, a surviving spouse's ability to waive a survivor's annuity or lump-sum payment, see *Boggs v. Boggs, 520 U.S. 833, 843, 117 S. Ct. 1754, 138 L. Ed. 2d 45*; *29 U.S.C. §§ 1055(a)*, *(b)(1)(C)*, *(c)(2)*, would be permissible under the **[***667]** Fifth Circuit's reading. These **[**867]** doubts, and exceptions calling the Fifth Circuit's reading into question, point the Court toward the law of trusts that "serves as ERISA's backdrop." *Beck v. PACE Int'l Union, 551 U.S. 96, 101, 127 S. Ct. 2310, 168 L. Ed. 2d 1*. *Section 1056(d)(1)* is much like a spendthrift trust provision barring assignment or alienation of a benefit, see *Boggs, supra, at 852, 117 S. Ct. 1754, 138 L. Ed. 2d 45*, and the cognate trust law is highly suggestive here. The general principle that a designated spendthrift beneficiary can disclaim his trust interest magnifies the improbability that a statute written with an eye on the old **[****4]** law would effectively force a beneficiary to take an interest willy-nilly. The Treasury reads its own regulation to mean that the antialienation provision is not violated by a beneficiary's waiver "where the beneficiary does not attempt to direct her interest in pension benefits to another person." Brief for United States as *Amicus Curiae* 18. Being neither "plainly erroneous [n]or inconsistent with the regulation," the Treasury Department's interpretation is controlling. *Auer v. Robbins, 519 U.S. 452, 461, 117 S. Ct. 905, 137 L. Ed. 2d 79*. ERISA's QDRO provisions shed no light on the validity of a waiver by a non-QDRO. Pp. 292-297.

(b) DuPont's additional reasons for saying that ERISA barred Liv's waiver are unavailing. Pp. 297-299.

2. Although Liv's waiver was not nullified by *§ 1056*'s express terms, the plan administrator did its ERISA duty by paying the SIP benefits to Liv in conformity with the plan documents. ERISA provides no exception to the plan administrator's duty to act in accordance with plan documents. Thus, the Estate's claim stands or falls by "the terms of the plan," *29 U.S.C. § 1132(a)(1)(B)*, a straightforward rule that lets employers "'establish a uniform administrative scheme, [with] a set of standard procedures **[****5]** to guide processing of claims and disbursement of benefits,'" *Egelhoff v. Egelhoff, 532 U.S. 141, 148, 121 S. Ct. 1322, 149 L. Ed. 2d 264*. By giving a plan participant a clear set of instructions for making his own instructions clear, ERISA forecloses any justification for enquiries into expressions of intent, in favor of the virtues of adhering to an uncomplicated rule. **[*287]** Less certain rules could force plan administrators to examine numerous external documents purporting to be waivers and draw them into

litigation like this over those waivers' meaning and enforceability. The guarantee of simplicity is not absolute, since a QDRO's enforceability may require an administrator to look for beneficiaries outside plan documents notwithstanding *§ 1104(a)(1)(D)*. But an administrator enforcing a QDRO must be said to enforce plan documents, not ignore them, and a QDRO enquiry is relatively discrete, given its specific and objective criteria. These are good and sufficient reasons for holding the line, just as the Court did in holding that ERISA preempted state laws that could blur the bright-line requirement to follow plan documents in distributing benefits. See *Boggs, supra, at 850, 117 S. Ct. 1754, 138 L. Ed. 2d 45*, and *Egelhoff, supra, at 143, 121 S. Ct. 1322, 149 L. Ed. 2d 264*. What goes for inconsistent **[****6]** state law goes for a federal common law of waiver that might obscure a plan administrator's duty to act "in accordance with the documents and instruments." See *Mertens v. Hewitt Associates, 508 U.S. 248, 259, 113 S. Ct. 2063, 124 L. Ed. 2d 161*. This case points out the wisdom **[***668]** of protecting the plan documents rule. Under the SIP, Liv was William's designated beneficiary. The plan provided a way to disclaim an interest in the SIP account, which Liv did not purport to follow. The plan administrator therefore did exactly what *§ 1104(a)(1)(D)* required and paid Liv the benefits. Pp. 299-304.

497 F.3d 426, affirmed.

Counsel: David A. Furlow argued the cause for petitioner.

Leondra R. Kruger argued the cause for the United States, as amicus curiae, by special leave of court.

Mark I. Levy argued the cause for respondents.

Judges: Souter, J., delivered the opinion for a unanimous Court.

Opinion by: SOUTER

Opinion

[*288] **[**868]** Justice **Souter** delivered the opinion of the Court.

[1] The Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, *29 U.S.C. § 1001 et seq.*, generally obligates administrators to manage ERISA plans "in accordance with the documents and instruments governing" them. *§ 1104(a)(1)(D)*. At a more specific level, the Act requires covered pension benefit plans to "provide that benefits . . . under the plan may not be assigned or alienated," *§ 1056(d)(1)*, but this bar does not apply to qualified domestic relations orders (QDROs), *§ 1056(d)(3)*. The

question **[****7]** here is whether the terms of the limitation on assignment or alienation invalidated the act of a divorced spouse, the designated beneficiary under her ex-husband's ERISA pension plan, who purported to waive her entitlement by a federal common law waiver embodied in a divorce decree that was not a QDRO. We hold that such a waiver is not rendered invalid by the text of the antialienation provision, but that the plan administrator properly disregarded the waiver owing to its conflict with the designation made by the former husband in accordance with plan documents.

I

The decedent, William Kennedy, worked for E. I. DuPont de Nemours & Company and was a participant in its savings and investment plan (SIP), with power both to "designate any beneficiary or beneficiaries . . . to receive all or part" of the funds upon his death, and to "replace or revoke such designation." App. 48. The plan requires "[a]ll authorizations, designations and requests concerning the Plan [to] be made by employees in the manner prescribed by the [plan administrator]," *id.*, at 52, and provides forms for designating or changing a beneficiary, *id.*, at 34, 56-57. If at the time the participant dies "no surviving spouse **[****8]** exists and no beneficiary designation is in effect, distribution shall be made to, or in accordance with the directions of, the executor or administrator of the decedent's estate." *Id.*, at 48.

[*289] The SIP is an ERISA "'employee pension benefit plan,'" *497 F.3d 426, 427 (CA5 2007)*; *29 U.S.C. § 1002(2)*, and the parties do not dispute that the plan satisfies ERISA's antialienation provision, *§ 1056(d)(1)*, which requires it to "provide that benefits provided under the plan may **[**869]** not be assigned or alienated."[1] The plan **[***669]** does, however, permit a beneficiary to submit a "qualified disclaimer" of benefits as defined under the Tax Code, see *26 U.S.C. § 2518*, which has the effect of switching the beneficiary to an "alternate . . . determined according to a valid beneficiary designation made by the deceased." Supp. Record 86-87 (Exh. 15).

In 1971, William married Liv Kennedy, and, in 1974, he signed a form designating her to take benefits under the SIP, but naming no contingent beneficiary to take if she disclaimed her interest. *497 F.3d at 427*. William and Liv divorced in 1994, subject to a decree that Liv "is . . . divested of all right, title, interest, and claim in and to . . . [a]ny and all sums . . . the proceeds [from], and any other rights related to any . . . retirement plan, pension plan, or like benefit program existing by reason of [William's] past or present or future employment." App. to Pet. for Cert. 64-65. William did not, however, execute any documents removing Liv as the SIP beneficiary, *497 F.3d at 428*, even though he did execute a new beneficiary-designation form naming his daughter, Kari Kennedy, as the beneficiary under DuPont's Pension and Retirement Plan, also governed by ERISA.

On William's death in 2001, petitioner Kari Kennedy was named executrix and **[****10]** asked DuPont to distribute the SIP **[*290]** funds to William's estate (hereinafter Estate). *Ibid.* DuPont, instead, relied on William's designation form and paid the balance of some $400,000 to Liv. *Ibid.* The Estate then sued respondents DuPont and the SIP plan administrator (together, DuPont), claiming that the divorce decree

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[1] The plan states that "[e]xcept as provided by ***Section 401(a)(13)*** of the [Internal Revenue] Code, no assignment of the rights or interests of account holders under this Plan will be permitted or recognized, nor shall such rights or interests be subject to attachment or other legal processes for debts." App. 50-51. Title ***26 U.S.C. § 401(a)(13)(A)***, in language substantially **[****9]** tracking the text of *§ 1056(d)(1)*, provides that "[a] trust shall not constitute a qualified trust under this section unless the plan of which such trust is a part provides that benefits provided under the plan may not be assigned or alienated."

amounted to a waiver of the SIP benefits on Liv's part, and that DuPont had violated ERISA by paying the benefits to William's designee.[2]

So far as it matters here, the District Court entered summary judgment for the Estate, to which it ordered DuPont to pay **[****11]** the value of the SIP benefits. The court relied on Fifth Circuit precedent establishing that a beneficiary can waive his rights to the proceeds of an ERISA plan "'provided that the waiver is explicit, voluntary, and made in good faith.'" App. to Pet. for Cert. 38 (quoting *Manning v. Hayes, 212 F.3d 866, 874 (CA5 2000)*).

The Fifth Circuit nonetheless reversed, distinguishing prior decisions enforcing federal common law waivers of ERISA benefits because they involved life-insurance policies, which are considered "'welfare plan[s]'" under ERISA and consequently free of the antialienation provision. *497 F.3d at 429*. The Court of Appeals held that Liv's waiver constituted an assignment or alienation of her interest in **[**870]** the SIP benefits to the Estate, and so could not be honored. *Id., at 430*. The court relied heavily on the ERISA provision for bypassing the antialienation provision when a marriage **[*291]** breaks up: under *29 U.S.C. § 1056(d)(3)*, **[***670]** [3] a court order that satisfies certain statutory requirements is known as a QDRO, which is exempt from the bar on assignment or alienation. Because the Kennedys' divorce decree was not a QDRO, the Fifth Circuit reasoned that it **[****12]** could not give effect to Liv's waiver incorporated in it, given that "ERISA provides a specific mechanism--the QDRO--for addressing the elimination of a spouse's interest in plan benefits, but that mechanism is *not* invoked." *497 F.3d at 431*.

We granted certiorari to resolve a split among the Courts of Appeals and State Supreme Courts over a divorced spouse's ability to waive pension plan benefits through a divorce decree not amounting to a QDRO.[4] *552 U.S. 1178, 128 S. Ct. 1225, 170 L. Ed. 2d 57 (2008)*. We subsequently realized that this case implicates the further split over whether a beneficiary's federal common law waiver of plan benefits is effective where that waiver is inconsistent with plan documents,[5] and after oral argument we invited supplemental briefing on that latter issue, upon **[*292]** which the disposition of this case ultimately turns. We now affirm, albeit on reasoning different **[****13]** from the Fifth Circuit's rationale.

II

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[2] The Estate now says that William's beneficiary-designation form for the Pension and Retirement Plan applied to the SIP as well, but the form on its face applies only to DuPont's "Pension and Retirement Plan." App. 62. In the District Court, in fact, the Estate stipulated that William "never executed any forms or documents to remove or replace Liv Kennedy as his sole beneficiary under either the SIP or [a plan that merged into the SIP]." *Id.*, at 28. In any event, the Estate did not raise this argument in the Court of Appeals, and we will not address it in the first instance. See *Taylor v. Freeland & Kronz, 503 U.S. 638, 645-646, 112 S. Ct. 1644, 118 L. Ed. 2d 280 (1992)*.

[3] *Section 1056(d)(3)(A)* provides that the antialienation provision "shall apply to the creation, assignment, or recognition of a right to any benefit payable with respect to a participant pursuant to a domestic relations order, except that paragraph (1) shall not apply if the order is determined to be a qualified domestic relations order."

[4] Compare *Altobelli v. IBM Corp., 77 F.3d 78 (CA4 1996)* (federal common law waiver in divorce decree does not conflict with antialienation provision); *Fox Valley & Vicinity Constr. Workers Pension Fund v. Brown, 897 F.2d 275 (CA7 1990)* (en banc) (same); *Keen v. Weaver, 121 S. W. 3d 721 (Tex. 2003)* (same), with *McGowan v. NJR Serv. Corp., 423 F.3d 241 (CA3 2005)* (federal common law waiver in divorce decree barred by antialienation provision).

[5] Compare *Altobelli, supra* (federal common law waiver controls); *Mohamed v. Kerr, 53 F.3d 911 (CA8 1995)* (same); *Brandon v. Travelers Ins. Co., 18 F.3d 1321 (CA5 1994)* (same); *Fox Valley, supra* (same); *Strong v. Omaha Constr. Industry Pension Plan, 270 Neb. 1, 701 N.W.2d 320 (2005)* (same); *Keen, supra* (same), with *Metropolitan Life Ins. Co. v. Marsh, 119 F.3d 415 (CA6 1997)* (plan documents control); *Krishna v. Colgate Palmolive Co., 7 F.3d 11 (CA2 1993)* (same).

A

[2] By its terms, the antialienation provision, *§ 1056(d)(1)*, requires a plan to provide expressly that benefits be neither "assigned" nor "alienated," the operative verbs having histories of legal meaning: to "assign" is "[t]o transfer; as to assign **[****14]** property, or some interest therein," Black's Law Dictionary 152 (4th rev. ed. 1968), and to "alienate" is "[t]o convey; to transfer the title to property," *id.*, at 96. We think it fair to say that Liv did not assign or alienate anything to William or to the Estate later standing in his shoes.

The Fifth Circuit saw the waiver as an assignment or alienation to the Estate, thinking that Liv's waiver transferred the SIP benefits to whoever would be next in line; without a designated contingent beneficiary, the Estate would take them. The court found support in the applicable Treasury Department regulation that defines "assignment" and "alienation" to include

> "[a]ny direct or indirect arrangement (whether revocable or irrevocable) whereby a party acquires from a participant **[**871]** or beneficiary a right or interest enforceable against the plan in, or to, all or any **[***671]** part of a plan benefit payment which is, or may become, payable to the participant or beneficiary." *26 CFR § 1.401(a)-13(c)(1)(ii) (2008)*.

See *Boggs v. Boggs, 520 U.S. 833, 851-852, 117 S. Ct. 1754, 138 L. Ed. 2d 45 (1997)* (relying upon the regulation to interpret the meaning of "assignment" and "alienation" in *§ 1056(d)(1)*). The Circuit treated Liv's waiver as an "'indirect **[****15]** arrangement'" whereby the Estate gained an "'interest enforceable against the plan.'" *497 F.3d at 430*.

Casting the alienation net this far, though, raises questions that leave one in doubt. Although it is possible to speak of **[*293]** the waiver as an "arrangement" having the indirect effect of a transfer to the next possible beneficiary, it would be odd usage to speak of an estate as the transferee of its own decedent's property, just as it would be to speak of the decedent in his lifetime as his own transferee. And treating the estate or even the ultimate estate beneficiary as the assignee or transferee would be strange under the terms of the regulation: it would be hard to say the estate or future beneficiary "acquires" a right or interest when at the time of the waiver there was no estate and the beneficiary of a future estate might be anyone's guess. If there were a contingent beneficiary (or the participant made a subsequent designation) the estate would get no interest; as for an estate beneficiary, the identity could ultimately turn on the law of intestacy applied to facts as yet unknown, or on the contents of the participant's subsequent will, or simply on the participant's future exercise **[****16]** of (or failure to invoke) the power to designate a new beneficiary directly under the terms of the plan. Thus, if such a waiver created an "arrangement" assigning or transferring anything under the statute, the assignor would be blindfolded, operating, at best, on the fringe of what "assignment" or "alienation" normally suggests.

The questionability of this broad reading is confirmed by exceptions to it that are apparent right off the bat. Take the case of a surviving spouse's interest in pension benefits, for example. Depending on the circumstances, a surviving spouse has a right to a survivor's annuity or to a lump-sum payment on the death of the participant, unless the spouse has waived the right and the participant has eliminated the survivor annuity benefit or designated a different beneficiary. See *Boggs, supra, at 843, 117 S. Ct. 1754, 138 L. Ed. 2d 45*; *29 U.S.C. §§ 1055(a)*, *(b)(1)(C)*, *(c)(2)*. This waiver by a spouse is plainly not barred by the antialienation provision. Likewise, DuPont concedes that a qualified disclaimer under the Tax Code, which allows a party to refuse an interest in property and thereby eliminate federal tax, would not violate

the antialienation **[*294]** provision. See Brief for Respondents 21-23; **[****17]** *26 U.S.C. § 2518*. In each example, though, we fail to see how these waivers would be permissible under the Fifth Circuit's reading of the statute and regulation.

Our doubts, and the exceptions that call the Fifth Circuit's reading into question, point us toward authority we have drawn on before, the law of trusts that "serves as ERISA's backdrop." *Beck v. PACE Int'l Union, 551 U.S. 96, 101, 127 S. Ct. 2310, 168 L. Ed. 2d 1 (2007)*. We explained before that *§ 1056(d)(1)* is much like a spendthrift trust provision barring assignment or alienation of a benefit, see *Boggs, supra, at 852, 117 S. Ct. 1754, 138 L. Ed. 2d 45*, and the cognate **[***672]** trust law is highly suggestive here. [3] Although the beneficiary of a spendthrift trust traditionally lacked the means to transfer his beneficial interest to anyone else, he did have the power to disclaim **[**872]** prior to accepting it, so long as the disclaimer made no attempt to direct the interest to a beneficiary in his stead. See 2 *Restatement (Third) of Trusts § 58(1), Comment c*, p. 359 (2001) ("A designated beneficiary of a spendthrift trust is not required to accept or retain an interest prescribed by the terms of the trust. . . . On the other hand, a purported disclaimer by which the beneficiary attempts to direct who is to **[****18]** receive the interest is a precluded transfer"); E. Griswold, Spendthrift Trusts § 524, p 603 (2d ed. 1947) ("The American cases, though not entirely clear, generally take the view that the interest under a spendthrift trust may be disclaimed"); *Roseberry v. Moncure, 245 Va. 436, 439, 429 S. E. 2d 4, 6, 9 Va. Law Rep. 1222 (1993)* ("'If a trust is created without notice to the beneficiary or the beneficiary has not accepted the beneficial interest under the trust, he can disclaim'" (quoting 1 A. Scott & W. Fratcher, Law of Trusts § 36.1, p 389 (4th ed. 1987) (hereinafter Fratcher))).

We do not mean that the whole law of spendthrift trusts and disclaimers turns up in *§ 1056(d)(1)*, but the general principle that a designated spendthrift can disclaim his trust interest magnifies the improbability that a statute written with an eye on the old law would effectively force a beneficiary **[*295]** to take an interest willy-nilly. Common sense and common law both say that "[t]he law certainly is not so absurd as to force a man to take an estate against his will." *Townson* v. *Tickell*, 3 Barn. & Ald. 31, 36, 106 Eng. Rep. 575, 576-577 (K. B. 1819).[6]

The Treasury is certainly comfortable with the state of the old law, for the way it reads its own regulation "no party 'acquires from' a beneficiary a 'right or interest enforceable against a plan' pursuant to a beneficiary's waiver of rights where the beneficiary does not attempt to direct her interest in pension benefits to another person." Brief for United States as *Amicus Curiae* 18. And, being neither "plainly

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[6] DuPont argues that Liv's waiver would have been an invalid disclaimer at common **[****19]** law because it was given for consideration in the divorce settlement. But the authorities DuPont cites fail to support the proposition that a beneficiary's otherwise valid disclaimer was invalid at common law because she received consideration. See *Roseberry v. Moncure, 245 Va., at 439, 429 S. E. 2d, at 6*; *Smith v. Bank of Del., 43 Del. Ch. 124, 126-127, 219 A.2d 576, 577 (1966)*; *Preminger v. Union Bank & Trust Co., 54 Mich. App. 361, 368-369, 220 N.W.2d 795, 798-799 (1974)*; 4 Fratcher § 337.1 (4th ed. 1989); 1 *Restatement (Second) of Trusts § 36, Comment c* (1957). It is true that the receipt of consideration prevents a beneficiary from making a qualified disclaimer for gift tax purposes, see *26 CFR § 25.2518-2 (2008)*, and there is common law authority for the proposition that a renunciation by a devisee is ineffective against existing creditors if "it is shown that those who would take such property on renunciation had agreed to pay to the devisee something of value in consideration of such renunciation." 6 W. Bowe & D. Parker, Page on Law of Wills § 49.5, p 48 (2005); see also *Schoonover v. Osborne, 193 Iowa 474, 478-479, 187 N. W. 20, 22 (1922)*. But at common law the receipt of **[****20]** consideration did not necessarily render a disclaimer invalid. See *Commerce Trust Co. v. Fast, 396 S.W.2d 683, 686-687 (Mo. 1965)*; *Central Nat. Bank v. Eells, 5 Ohio Misc. 187, 189-192, 215 N.E.2d 77, 80-81 (Ohio P. Ct. 1965)*; *In re Wimperis*, [1914] 1 Ch. 502, 508-510; see also *In re Estate of Baird, 131 Wn. 2d 514, 519, n. 5, 933 P.2d 1031, 1034, n. 5 (1997)*. In any event, our point is not that Liv's waiver was a valid disclaimer at common law: only that reading the terms of *29 U.S.C. § 1056(d)(1)* to bar all non-QDRO waivers is unsound in light of background common law principles.

erroneous [n]or inconsistent with the regulation," the Treasury **[*296]** Department's interpretation of its **[***673]** regulation is controlling. *Auer v. Robbins, 519 U.S. 452, 461, 117 S. Ct. 905, 137 L. Ed. 2d 79 (1997)* (internal quotation marks omitted).[7]

[873]** The Fifth Circuit found "significant support" for its contrary holding in the QDRO subsections, reasoning that "[i]n the marital-dissolution context, the QDRO provisions supply the *sole* exception to the anti-alienation provision," *497 F.3d at 430*, a point that echoes in DuPont's argument here. But the negative implication of the QDRO language is not that simple. If a QDRO provided a way for a former spouse like Liv merely to waive benefits, this would be powerful evidence that the antialienation provision was meant to deny any effect to a waiver within a divorce decree but not a QDRO, else there would have been no need for the QDRO exception. But this is not so, and DuPont's argument rests on a false premise. In fact, [4] a beneficiary seeking only to relinquish her right to benefits cannot do this by a QDRO, for a QDRO by definition requires that it be the "creat[ion] or recogni[tion of] the existence of an alternate payee's right to, or assign[ment] to an alternate payee [of] the right **[*297]** to, receive all or a portion of the benefits payable with respect to a participant under a plan." *29 U.S.C. § 1056(d)(3)(B)(i)(I)*. There is no QDRO for a simple waiver; **[****23]** there must be some succeeding designation of an alternate payee.[8] Not being a mechanism for simply renouncing a claim to benefits, then, the QDRO provisions shed no light on whether a beneficiary may waive by a non-QDRO.

In sum, Liv did not attempt to direct her interest in the SIP benefits to the Estate or any other potential beneficiary, and accordingly we think that the better view is that her waiver did not constitute an assignment or alienation rendered void under the terms of *§ 1056(d)(1)*.

B

DuPont has three other reasons for saying that Liv's waiver was barred by ERISA. They are unavailing.

First, it argues that even if the waiver is not an assignment or alienation barred under the terms of *§ 1056(d)(1)*, *§ 1056(d)(3)(A)* still prohibits it, in providing **[****24]** that *§ 1056(d)(1)* "shall apply to the creation, assignment, or recognition of a **[***674]** right to any benefit payable with respect to a participant pursuant to a domestic relations order [that is not a QDRO]." At the very least, DuPont reasons, Liv's waiver included a "recognition" of William's rights with respect to the SIP benefits. But DuPont overlooks the point that when **[**874]** *subsection (d)(3)(A)* provides that the bar to assignments

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[7] It is true that the **[****21]** Government's position regarding the applicability of the antialienation provision to a waiver has fluctuated. The Labor Department previously took the position that "application of such a federal common-law waiver rule to pension plans would conflict with ERISA's anti-alienation provision." Brief for Secretary of Labor as *Amicus Curiae* p. 16.in *Keen* v. *Weaver*, No. 01-0447 (Tex. 2003). And it likewise asserted that "waiver of pension benefits is generally impermissible under *[§ 1056(d)(1)]*." Brief for Secretary of Labor as *Amicus Curiae* p. 5 in *In re Estate of Egelhoff*, No. 67626-7 (Wash. 2001), p. 5.. The Labor Department has reconsidered that view and has now taken the Treasury's position. Brief for United States as *Amicus Curiae* 20, n 6. But "the change in interpretation alone presents no separate ground for disregarding the [Treasury's and the Labor] Department's present interpretation." *Long Island Care at Home, Ltd. v. Coke, 551 U.S. 158, 171, 127 S. Ct. 2339, 168 L. Ed. 2d 54 (2007)*. Nor does the fact that the interpretation is stated in a legal brief make it unworthy of deference, as "[t]here is simply no reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in **[****22]** question." *Auer, 519 U.S., at 462, 117 S. Ct. 905, 137 L. Ed. 2d 79*.

[8] Even if one understands Liv's waiver to have resulted somehow in her interest reverting to William, he does not qualify as [5] an "alternate payee," which is defined by statute as "any spouse, former spouse, child, or other dependent of a participant who is recognized by a domestic relations order as having a right to receive all, or a portion of, the benefits payable under a plan with respect to such participant." *29 U.S.C. § 1056(d)(3)(K)*.

or alienations extends to non-QDROs, it does nothing to expand the scope of prohibited assignment and alienation under *subsection (d)(1)*. Whether Liv's action is seen as a waiver or as a domestic relations order that incorporated a waiver, *subsection (d)(1)* **[*298]** does not cover it and *§ 1056(d)(3)(A)* does not independently bar it.

Second, DuPont relies upon *§ 1056(d)(3)(H)(iii)(II)*, providing that if a domestic relations order is not a QDRO, "the plan administrator shall pay the segregated amounts (including any interest thereon) to the person or persons who would have been entitled to such amounts if there had been no order." According to DuPont, because the divorce decree was not a QDRO this provision calls for paying benefits as if there had **[****25]** been no order. But DuPont has wrenched this language out of its setting, reading clause (iii) of subparagraph (H) as if there were no clause (i):

> [6] "During any period in which the issue of whether a domestic relations order is a qualified [QDRO] domestic relations order is being determined . . . the plan administrator shall separately account for the amounts (hereinafter in this subparagraph referred to as the 'segregated amounts') which would have been payable to the alternate payee during such period if the order had been determined to be a [QRDO]." *§ 1056(d)(3)(H)(i)*.

Thus it is clear that subparagraph (H) speaks of a domestic relations order that distributes certain benefits (the "segregated amounts") to an alternate payee, when the question for the plan administrator is whether the order is effective as a QDRO. That is the circumstance in which, for want of a QDRO, clause (iii) tells the plan administrator not to pay the alternate, but to distribute the segregated amounts as if there had been no order. Clause (iii) does not, as DuPont suggests, state a general rule that a non-QDRO is a nullity in any proceeding that would affect the determination **[****26]** of a beneficiary. And of course clause (iii) says nothing here at all; the divorce decree names no alternate payee, and there are consequently no "segregated amounts."

Third, DuPont claims that a plan cannot recognize a waiver of benefits in a non-QDRO divorce decree because **[*299]** ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan," with "State law" being defined to include "decisions" or "other State action having the effect of law."[9] *§§ 1144(a)*, *(c)(1)*. DuPont says that Liv's waiver, expressed in a state-court decision and related to an employee benefit plan, is thus preempted. But recognizing a waiver in a divorce decree would not be giving effect to state law; the argument is that the waiver should be treated as a creature of federal common law, in which case its setting in a state divorce decree would be only happenstance. A court would merely be applying **[***675]** federal law to a document that might also have independent significance under state law. See, *e.g.*, *Melton v. Melton, 324 F.3d 941, 945-946 (CA7 2003)*; *Clift v. Clift, 210 F.3d 268, 271-272 (CA5 2000)*; *Lyman Lumber Co. v. Hill, 877 F.2d 692, 693-694 (CA8 1989)*.

III

The waiver's escape from inevitable nullity under the express terms of the antialienation clause does not, however, control the decision of this case, and the **[**875]** question remains whether the plan administrator was required to honor Liv's waiver with the consequence of distributing the SIP balance to

[9] This preemption **[****27]** provision does not apply to QDROs. See *§ 1144(b)(7)*.

the Estate.[10] We hold that it was not, and that the plan **[*300]** administrator did its statutory ERISA duty by paying the benefits to Liv in conformity with the plan documents.

[7] ERISA requires "[e]very employee benefit plan [to] be established and maintained pursuant to a written instrument," *29 U.S.C. § 1102(a)(1)*, "specify[ing] the basis on which payments are made to and from the plan," *§ 1102(b)(4)*. The plan administrator is obliged to act "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [Title I] and [Title IV] of [ERISA]," *§ 1104(a)(1)(D)*, and ERISA provides no exemption from this duty when it comes time to pay benefits. On the contrary, *§ 1132(a)(1)(B)* **[****29]** (which the Estate happens to invoke against DuPont here) reinforces the directive, with its provision that a participant or beneficiary may bring a cause of action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."

The Estate's claim therefore stands or falls by "the terms of the plan," *§ 1132(a)(1)(B)*, a straightforward rule of hewing to the directives of the plan documents that lets employers "'establish a uniform administrative scheme, [with] a set of standard procedures to guide processing of claims and disbursement of benefits.'"[11] *Egelhoff v. Egelhoff, 532 U.S. 141, 148, 121 S. Ct. 1322, 149 L. Ed. 2d 264 (2001)* (quoting *Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9, 107 S. Ct. 2211, 96 L. Ed. 2d 1 (1987)*; see also *Curtiss-Wright Corp. v. **[*301]** Schoonejongen, **[***676]** 514 U.S. 73, 83, 115 S. Ct. 1223, 131 L. Ed. 2d 94 (1995)* (ERISA's statutory scheme "is built around reliance on the face of written plan documents"). The point is that by giving a plan participant a clear set of instructions for making his own instructions clear, ERISA forecloses any justification for enquiries into nice expressions of intent, in favor of the virtues of adhering to an uncomplicated **[****30]** rule: "simple administration, avoid[ing] double liability, and ensur[ing] that beneficiaries get what's coming quickly, without the folderol essential **[**876]** under less-certain rules." *Fox Valley & Vicinity Constr. Workers Pension Fund v. Brown, 897 F.2d 275, 283 (CA7 1990)* (Easterbrook, J., dissenting).

And the cost of less certain rules would be too plain. Plan administrators would be forced "to examine a multitude of external documents that might purport to affect the dispensation of benefits," *Altobelli v. IBM Corp., 77 F.3d 78, 82-83 (CA4 1996)* (Wilkinson, C. J., dissenting), and be drawn into litigation like this over the meaning and enforceability of purported waivers. The Estate's suggestion that a plan administrator could resolve these sorts of disputes through interpleader actions merely restates the problem with the Estate's position: it would destroy a plan administrator's ability to look at the plan

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[10] Despite our following answer to the question here, our conclusion that *§ 1056(d)(1)* does not make a nullity of a waiver leaves open any questions about a waiver's effect in circumstances in which it is consistent with plan documents. Nor do we express any view as to whether the Estate could have brought an action in state or federal court against Liv to obtain the benefits after they were distributed. Compare *Boggs v. Boggs, 520 U.S. 833, 853, 117 S. Ct. 1754, 138 L. Ed. 2d 45 (1997)* ("If state law is not pre-empted, the diversion of retirement benefits will occur regardless of whether the interest in the pension plan is enforced against the plan or the recipient of the pension benefit"), with *Sweebe v. Sweebe, 474 Mich. 151, 156-159, 712 N.W.2d 708, 712-713 (2006)* **[****28]** (distinguishing *Boggs* and holding that "while a plan administrator must pay benefits to the named beneficiary as required by ERISA," after the benefits are distributed "the consensual terms of a prior contractual agreement may prevent the named beneficiary from retaining those proceeds"); *Pardee v. Pardee, 2005 OK CIV App. 27, PP20, 27, 112 P. 3d 308, 313-314, 315-316 (2004)* (distinguishing *Boggs* and holding that ERISA did not preempt enforcement of allocation of ERISA benefits in state-court divorce decree as "the pension plan funds were no longer entitled to ERISA protection once the plan funds were distributed").

[11] We express no view regarding the ability of a participant or beneficiary to bring a cause of action under *29 U.S.C. § 1132(a)(1)(B)* where the terms of the plan fail to conform to the requirements of ERISA and the party seeks to recover under the terms of the statute.

documents and **[****31]** records conforming to them to get clear distribution instructions, without going into court.

The Estate of course is right that this guarantee of simplicity is not absolute. [8] The very enforce-ability of QDROs means that sometimes a plan administrator must look for the beneficiaries outside plan documents notwithstanding *§ 1104(a)(1)(D)*; *§ 1056(d)(3)(J)* provides that a "person who is an alternate payee under a [QDRO] shall be considered for purposes of any provision of [ERISA] a beneficiary under the plan." But this in effect means that a plan administrator who enforces a QDRO must be said to enforce plan documents, not ignore them. In any case, a QDRO enquiry is relatively discrete, given the specific and objective criteria **[*302]** for a domestic relations order that qualifies as a QDRO,[12] see *§§ 1056(d)(3)(C)*, *(D)*, requirements that amount to a statutory checklist working to "spare [an administrator] from litigation-fomenting ambiguities," *Metropolitan Life Ins. Co. v. Wheaton, 42 F.3d 1080, 1084 (CA7 1994)*. This is a far cry from asking a plan administrator to figure out whether a claimed federal common law waiver was knowing and voluntary, whether its language addressed the particular benefits **[****32]** at issue, and so forth, on into factually complex and subjective determinations. See, *e.g.*, *Altobelli, supra, at 83* (Wilkinson, C. J., dissenting) **[***677]** ("[W]aiver provisions are often sweeping in their terms, leaving their precise effect on plan benefits unclear"); *Mohamed v. Kerr, 53 F.3d 911, 915 (CA8 1995)* (making "fact-driven determination" that marriage termination agreement constituted a valid waiver under federal common law).

These are good and sufficient reasons for holding the line, just as we have done in cases of state laws that might blur the bright-line requirement to follow plan documents in distributing benefits. Two recent preemption cases are instructive here. *Boggs v. Boggs, 520 U.S. 833, 117 S. Ct. 1754, 138 L. Ed. 2d 45*, held that ERISA preempted a state law permitting the testamentary transfer of a nonparticipant spouse's community property interest **[*303]** in undistributed pension plan benefits. We **[**877]** rejected the entreaty to create "through case law . . . a new class of persons for whom plan assets are to be held and administered," explaining that "[t]he statute is not amenable to this sweeping extratextual extension." *Id., at 850, 117 S. Ct. 1754, 138 L. Ed. 2d 45*. And in *Egelhoff* we held that ERISA preempted a state law providing that the designation of a spouse as the beneficiary of a nonprobate asset is revoked automatically upon divorce. *532 U.S., at 143, 121 S. Ct. 1322, 149 L. Ed. 2d 264*. We said the law was at fault for standing in **[****34]** the way of making payments "simply by identifying the beneficiary specified by the plan documents," *id., at 148, 121 S. Ct. 1322, 149 L. Ed. 2d 264*, and thus for purporting to "undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators," *id., at 149-150, 121 S. Ct. 1322, 149 L. Ed. 2d 264* (quoting *Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142, 111 S. Ct. 478, 112 L. Ed. 2d 474 (1990)*; see *Egelhoff, supra, at 147, n. 1, 121 S. Ct. 1322, 149 L. Ed. 2d 264* (identifying "the conflict between the plan documents (which require making payments to the named beneficiary) and the statute (which requires making payments to someone else)").

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[12] [9] To qualify as a QDRO, a divorce decree must "clearly specif[y]" the name and last known mailing address of the participant and the name and mailing address of each alternate payee covered by the order; the amount or percentage of the participant's benefits to be paid by the plan to each such alternate payee or the manner in which such amount or percentage is to be determined; the number of payments or period to which the order applies; and each plan to which such order applies. *§ 1056(d)(3)(C)*. A domestic relations order cannot qualify as a QDRO if it requires a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan; requires the plan to provide increased benefits; or requires the payment of benefits to an alternate **[****33]** payee that are required to be paid to another alternate payee under another order previously determined to be a QDRO. *§ 1056(d)(3)(D)*. A plan is required to establish written procedures for determining whether a domestic relations order is a QDRO. *§ 1056(d)(3)(G)(ii)*.

What goes for inconsistent state law goes for a federal common law of waiver that might obscure a plan administrator's duty to act "in accordance with the documents and instruments." See *Mertens v. Hewitt Associates, 508 U.S. 248, 259, 113 S. Ct. 2063, 124 L. Ed. 2d 161 (1993)* ([10] "The authority of courts to develop a 'federal common law' under ERISA . . . is not the authority to revise the text of the statute"). And this case does as well as any other in pointing out the wisdom of protecting the plan documents rule. Under the terms of the SIP Liv was William's designated beneficiary. The plan provided an easy way for William to change the designation, but for whatever reason **[****35]** he did not. The plan provided a way to disclaim an interest in the SIP account, but Liv did not purport to follow it.[13] **[*304]** The plan administrator therefore did exactly what *§ 1104(a)(1)(D)* required: "the documents control, and those name [the ex-wife]." *McMillan v. Parrott, 913 F.2d 310, 312 (CA6 1990)*.

It is no answer, as the Estate argues, that William's beneficiary-designation form should not control because it is not one of the "documents and instruments governing the plan" under *§ 1104(a)(1)(D)* and was **[***678]** not treated as a plan document by the plan administrator. That is beside the point. It is uncontested that the SIP and the summary plan description are "documents and instruments governing the plan." See *Curtiss-Wright Corp., 514 U.S., at 84, 115 S. Ct. 1223, 131 L. Ed. 2d 94* (explaining that *29 U.S.C. §§ 1024(b)(2)* and *(b)(4)* require a plan administrator to make available the "governing plan documents"). Those documents provide that the plan administrator will pay benefits to a participant's **[****36]** designated beneficiary, with designations and changes to be made in a particular way. William's designation of Liv as his beneficiary was made in the way required; Liv's waiver was not.[14]

[878]** IV

Although Liv's waiver was not rendered a nullity by the terms of *§ 1056*, the plan administrator properly distributed the SIP benefits to Liv in accordance with the plan documents. The judgment of the Court of Appeals is affirmed on the latter ground.

It is so ordered.

References

29 U.S.C.S. § 1056(d)(3)

6 Labor and Employment Law § 154.06 (Matthew Bender)

L Ed Digest, Pensions and Retirement Funds §§ 11, 12

[13] The Estate does not contend that Liv's waiver was a valid disclaimer under the terms of the plan. We do not address a situation in which the plan documents provide no means for a beneficiary to renounce an interest in benefits.

[14] The Estate also contends that requiring a plan administrator to distribute benefits in conformity with plan documents will allow a beneficiary who murders a participant to obtain benefits under the terms of the plan. The "slayer" case is not before us, and we do not address it. See *Egelhoff v. Egelhoff, 532 U.S. 141, 152, 121 S. Ct. 1322, 149 L. Ed. 2d 264 (2001)* (declining to decide whether ERISA preempts state statutes forbidding a murdering heir from receiving property as a result of the killing).

L Ed Index, Pensions and Retirement

Supreme Court's construction and application of § 502 of Employee Retirement Income Security Act of 1974 (ERISA), as amended (*29 U.S.C.S. § 1132*) providing for civil enforcement of ERISA. 151 L. Ed. 2d 1083. **[****37]**

When do individuals or entities act as covered fiduciaries, for purposes of Employee Retirement Income Security Act of 1974, as amended (ERISA) (*29 U.S.C.S. § 1001 et seq.*)--Supreme Court cases. 142 L. Ed. 2d 1043.

When is state or local law pre-empted by Employee Retirement Income Security Act of 1974, as amended (ERISA) (*29 U.S.C.S. § 1001 et seq.*)--Supreme Court cases. 121 L. Ed. 2d 783.

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QDROs

The Division of Retirement Benefits Through Qualified Domestic Relations Orders

U.S. Department of Labor
Employee Benefits Security Administration

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QDROs

The Division of Retirement Benefits Through Qualified Domestic Relations Orders

U.S. Department of Labor
Employee Benefits Security Administration
2014

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Introduction

More than 46 million private wage and salary workers are currently covered by employer-provided retirement plans in the United States. For many of these Americans, retirement savings represent one of their most significant assets. For this reason, whether and how to divide a participant's interest in a retirement plan are often important considerations in separation, divorce, and other domestic relations proceedings. While the division of marital property generally is governed by state domestic relations law, any assignments of retirement interests must also comply with Federal law, namely the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code of 1986 (the Code). Under ERISA and the Code, retirement interests may be assigned only if the judgment, decree, or order creating or recognizing a spouse's, former spouse's, child's, or other dependent's interest in an individual's retirement benefits constitutes a "qualified domestic relations order" or "QDRO."

This booklet was prepared by the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to provide general guidance about QDROs[1] to employers, retirement plan administrators, participants, beneficiaries, employee benefit professionals, and domestic relations specialists. The views expressed in this booklet represent the views of the Department of Labor.

This publication provides general information about the qualified domestic relations orders (QDROs) under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code of 1986. More information about QDROs submitted to the Pension Benefit Guaranty Corporation after a retirement plan terminates and PBGC becomes the trustee is available from the Pension Benefit Guaranty Corporation at www.pbgc.gov.

Chapter 1 provides a general overview of the QDRO provisions and the basic rules governing the content of QDROs.

Chapter 2 focuses on the duties of retirement plan administrators in making QDRO determinations and in administering retirement plans for which related QDROs have been issued.

[1]The Department of Labor has jurisdiction to interpret the QDRO provisions set forth in section 206(d)(3) of ERISA and section 414(p) of the Code (except to the extent provided in section 401(n) of the Code) and the provisions governing fiduciary duties owed with respect to domestic relations orders and QDROs. This booklet was developed in consultation with the Department of the Treasury and the Internal Revenue Service.

Chapter 3 focuses on issues to be considered in drafting a QDRO. This chapter also discusses the provisions of section 205 of ERISA, which are substantially parallel to the provisions contained in sections 401(a)(11) and 417 of the Code to the extent these sections apply to QDROs. The provisions of section 205 require that retirement plans provide the spouses of retirement plan participants with certain rights to survivor benefits, which are relevant to the provisions governing QDROs. Sample QDRO language developed by the Department of the Treasury and the Internal Revenue Service, in consultation with the Department of Labor, is provided in Appendix C.

It is the hope of EBSA that the information furnished in this booklet will promote better understanding of the rights and obligations of those involved in domestic relations proceedings and those responsible for administering retirement plans.[2] A better understanding of these provisions of law should reduce the costs and burdens associated with QDRO determinations for both retirement plans and the affected individuals.

The Department recognizes that this booklet does not answer every question that may arise in the development and administration of QDROs. In this regard, the Department is willing to consider addressing specific issues through its advisory opinion process (*but see* Question 1-15 regarding advisory opinion requests on whether a domestic relations order is a QDRO). The ERISA Advisory Opinion Procedure governing this process is set forth in Appendix B of this booklet.

2 As used in this booklet, the term "retirement plan" refers to plans defined in section 3(2) of ERISA and means generally any plan established or maintained by an employer or an employee organization (or both) that provides retirement income to employees or results in the deferral of income by employees for periods extending to the termination of covered employment or beyond.

Chapter 1
Qualified Domestic Relations Orders: An Overview

This chapter includes a general overview of the provisions of Federal law governing the assignment of retirement benefits in a domestic relations proceeding and the requirements that apply in determining whether a domestic relations order is a qualified domestic relations order (QDRO). The following areas are addressed:

- Who can be an "alternate payee"?
- What information must be included in a domestic relations order in order for it to be "qualified"?
- Who determines whether a domestic relations order is a QDRO?

In general, ERISA and the Code do not permit a participant to assign or alienate the participant's interest in a retirement plan to another person. These "anti-assignment and alienation" rules are intended to ensure that a participant's retirement benefits are actually available to provide financial support during the participant's retirement years. A limited exception to the anti-assignment and alienation rules is provided for assignments of retirement benefits through qualified domestic relations orders (QDROs).

Under the QDRO exception, a domestic relations order may assign some or all of a participant's retirement benefits to a spouse, former spouse, child, or other dependent to satisfy family support or marital property obligations if and only if the order is a "qualified domestic relations order." ERISA requires that each retirement plan pay benefits in accordance with the applicable requirements of any "qualified domestic relations order" that has been submitted to the plan administrator. The plan administrator's determinations on whether a domestic relations order is a QDRO, therefore, have significant implications for both the parties to a domestic relations proceeding and the plan. The following questions and answers are intended to provide an overview of the Federal requirements a domestic relations order must satisfy to be considered a QDRO.

Q 1-1: What is a Qualified Domestic Relations Order?

A "qualified domestic relations order" (QDRO) is:

- a domestic relations order
- that creates or recognizes the existence of an "alternate payee's" right to receive, or assigns to an alternate payee the right to receive, all or a portion of the benefits payable with respect to a participant under a retirement plan, and
- that includes certain information and meets certain other requirements. *See* Questions 1-5 and 1-6.

Question 1-4 explains who may be an "alternate payee."

[ERISA § 206(d)(3)(B)(i); IRC § 414(p)(1)(A)]

Q 1-2: What is a "domestic relations order"?

To be recognized as a QDRO, an order must be a "domestic relations order." A domestic relations order is:

- a judgment, decree, or order (including the approval of a property settlement)
- that is made pursuant to state domestic relations law (including community property law) and
- that relates to the provision of child support, alimony payments, or marital property rights for the benefit of a spouse, former spouse, child, or other dependent of a participant.

A state authority, generally a court, must actually issue a judgment, order, or decree or otherwise formally approve a property settlement agreement before it can be a "domestic relations order" under ERISA. The mere fact that a property settlement is agreed to and signed by the parties will not, in and of itself, cause the agreement to be a domestic relations order.

There is no requirement that both parties to a marital proceeding sign or otherwise endorse or approve an order. It is also not necessary that the retirement plan be brought into state court or made a party to a domestic relations proceeding for an order issued in that proceeding to be a "domestic relations order" or a "qualified domestic relations order." Indeed, because state law is generally preempted to the extent that it relates to retirement plans, the Department takes the position that retirement plans cannot be joined as a party in a domestic relations proceeding pursuant to state law. Moreover, retirement plans are neither permitted nor required to follow the terms of domestic relations orders purporting to assign retirement benefits unless they are QDROs.

[ERISA §§ 206(d)(3)(B)(ii), 514(a), 514(b)(7); IRC § 414(p)(1)(B)]

Q 1-3: Must a "domestic relations order" be issued by a state court?

No. A domestic relations order may be issued by any state agency or instrumentality with the authority to issue judgments, decrees, or orders, or to approve property settlement agreements, pursuant to state domestic relations law (including community property law).

[ERISA § 206(d)(3)(B)(ii); IRC § 414(p)(1)(B); Advisory Opinion 2001-06A (Appendix A)]

Q 1-4: Who can be an "alternate payee"?

A domestic relations order can be a QDRO only if it creates or recognizes the existence of an alternate payee's right to receive, or assigns to an alternate payee the right to receive, all or a part of a participant's benefits.

For purposes of the QDRO provisions, an alternate payee cannot be anyone other than a spouse, former spouse, child, or other dependent of a participant.

[ERISA § 206(d)(3)(K), IRC § 414(p)(8)]

Q 1-5: What information must a domestic relations order contain to qualify as a QDRO under ERISA?

QDROs must contain the following information:

- the name and last known mailing address of the participant and each alternate payee;
- the name of each plan to which the order applies;
- the dollar amount or percentage (or the method of determining the amount or percentage) of the benefit to be paid to the alternate payee; and
- the number of payments or time period to which the order applies.

[ERISA § 206(d)(3)(C)(i)-(iv); IRC § 414(p)(2)(A)-(D)]

Q 1-6: Are there other requirements that a domestic relations order must meet to be a QDRO?

Yes. There are certain provisions that a QDRO must not contain:

- The order must <u>not</u> require a plan to provide an alternate payee or participant with any type or form of benefit, or any option, not otherwise provided under the plan;
- The order must <u>not</u> require a plan to provide for increased benefits (determined on the basis of actuarial value);
- The order must <u>not</u> require a plan to pay benefits to an alternate payee that are required to be paid to another alternate payee under another order previously determined to be a QDRO; and

- The order must not require a plan to pay benefits to an alternate payee in the form of a qualified joint and survivor annuity for the lives of the alternate payee and his or her subsequent spouse.

[ERISA §§ 206(d)(3)(D)(i)-(iii), 206(d)(3)(E)(i)(III); IRC §§ 414(p)(3)(A)-(C), 414(p)(4)(A)(iii)]

Q 1-7: May a QDRO be part of the divorce decree or property settlement?

Yes. There is nothing in ERISA or the Code that requires that a QDRO (that is, the provisions that create or recognize an alternate payee's interest in a participant's retirement benefits) be issued as a separate judgment, decree, or order. Accordingly, a QDRO may be included as part of a divorce decree or court- approved property settlement, or issued as a separate order, without affecting its "qualified" status. The order must satisfy the requirements described above to be a QDRO.

[*See generally* ERISA § 206(d)(3)(B); IRC § 414(p)(1)]

Q 1-8: Must a domestic relations order be issued as part of a divorce proceeding to be a QDRO?

No. A domestic relations order that provides for child support or recognizes marital property rights may be a QDRO, without regard to the existence of a divorce proceeding. Such an order, however, must be issued pursuant to state domestic relations law and create or recognize the rights of an individual who is an "alternate payee" (spouse, former spouse, child, or other dependent of a participant).

An order issued in a probate proceeding begun after the death of the participant that purports to recognize an interest with respect to retirement benefits arising solely under state community property law, but that doesn't relate to the dissolution of a marriage or recognition of support obligations, is not a QDRO because the proceeding does not relate to a legal separation, marital dissolution, or family support obligation.

[ERISA § 206(d)(3)(B); IRC § 414(p)(1); Advisory Opinion 90-46A (Appendix A); *see* Egelhoff v. Egelhoff, 121 S.Ct. 1322, 149L. Ed. 2d 264 (2001); *see* Boggs v. Boggs, 520 U.S. 833, 117 S.Ct. 1754 (1997)]

Q 1-9: Will a domestic relations order fail to be a QDRO solely because of the timing of issuance?

No, not if it otherwise meets the QDRO requirements under ERISA. A domestic relations order issued after the participant's death, divorce, or annuity starting date, or subsequent to an existing QDRO, will not fail to be treated as a QDRO solely because of the timing of issuance. For example, a subsequent domestic relations order between the same parties which revises an earlier QDRO does not fail to be a QDRO solely because it was issued after the first QDRO. Likewise, a subsequent domestic relations order between different parties which directs a portion of the participant's previously unallocated benefits to a second alternate payee, does not fail to be a QDRO solely because of the existence of a previous QDRO. Further, a domestic relations order requiring a portion of a participant's annuity benefit payments be paid to an alternate payee does not fail to be a QDRO solely because the domestic relations order was issued after the annuity starting date.

[29 C.F.R. 2530.206; *see* section 1001 of the Pension Protection Act of 2006, Pub. L. 109-280, 120 Stat. 780 (Aug. 17, 2006)]

Q 1-10 : May a QDRO provide for payment to the guardian of an alternate payee?

Yes. If an alternate payee is a minor or is legally incompetent, the order can require payment to someone with legal responsibility for the alternate payee (such as a guardian or a party acting in *loco parentis* in the case of a child, or a trustee as agent for the alternate payee).

[*See* Staff of the Joint Committee on Taxation, Explanation of Technical Corrections to the Tax Reform Act of 1984 and Other Recent Tax Legislation, 100th Cong., 1st Sess. (Comm. Print 1987) at 222.]

Q 1-11: Can a QDRO cover more than one plan?

Yes. A QDRO can assign rights to retirement benefits under more than one retirement plan of the same or different employers as long as each plan and the assignment of benefit rights under each plan are clearly specified.

[ERISA § 206(d)(3)(C)(iv); IRC § 414(p)(2)(D)]

Q 1-12: Must all QDROs have the same provisions?

No. Although every QDRO must contain certain provisions, such as the names and addresses of the participant and alternate payee(s) and the name of the plan(s), the specific content of the rest of the QDRO will depend, as explained in more detail in Chapter 3, on the type of retirement plan, the nature of the participant's retirement benefits, the purposes behind issuing the order, and the intent of the drafting parties.

Q 1-13: Who determines whether an order is a QDRO?

Under Federal law, the administrator of the retirement plan that provides the benefits affected by an order is the individual (or entity) initially responsible for determining whether a domestic relations order is a QDRO. Plan administrators have specific responsibilities and duties with respect to determining whether a domestic relations order is a QDRO. Plan administrators, as plan fiduciaries, are required to discharge their duties prudently and solely in the interest of plan participants and beneficiaries. Among other things, plans must establish reasonable procedures to determine the qualified status of domestic relations orders and to administer distributions pursuant to qualified orders. Administrators are required to follow the plan's procedures for making QDRO determinations. Administrators also are required to furnish notice to participants and alternate payees of the receipt of a domestic relations order and to furnish

a copy of the plan's procedures for determining the qualified status of such orders. *See* Chapter 2 for a detailed discussion of the duties and responsibilities of plan administrators in making QDRO determinations.

It is the view of the Department of Labor that a state court (or other state agency or instrumentality with the authority to issue domestic relations orders) does not have jurisdiction to determine whether an issued domestic relations order constitutes a "qualified domestic relations order." In the view of the Department, jurisdiction to challenge a plan administrator's decision about the qualified status of an order lies exclusively in Federal court.

[ERISA §§ 206(d)(3)(G)(i) and (ii), 404(a), 502(a)(3), 502(e), 514; IRC § 414(p)(6)(A)(ii)]

Q 1-14: Who is the "administrator" of the plan?

The "administrator" of an employee benefit plan is the individual or entity specifically designated in the plan documents as the administrator. If the plan documents do not designate an administrator, the administrator is the employer maintaining the plan, or, in the case of a plan maintained by more than one employer, the association, committee, joint board of trustees, or similar group representing the parties maintaining the plan. The name, address, and phone number of the plan administrator is required to be included in the plan's summary plan description. The summary plan description is a document that the administrator is required to furnish to each participant and to each beneficiary receiving benefits. It summarizes the rights and benefits of participants and beneficiaries and the obligations of the plan.

[ERISA §§ 3(16), 102(b), 29 CFR § 2520.102-3(f); IRC § 414(g), Treas. Reg. § 1.414(g)-1]

Q 1-15: Will the Department of Labor issue advisory opinions on whether a domestic relations order is a QDRO?

No. A determination of whether an order is a QDRO necessarily requires an interpretation of the specific provisions of the plan or plans to which the order applies and the application of those provisions to specific facts, including a determination of the participant's actual retirement benefits under the plan(s). The Department will not issue opinions on such inherently factual matters.

[*See* ERISA Procedure 76-1, 41 Fed. Reg. 36281 (1976) (Appendix B)]

Chapter 2
Administration of QDRO: Determining Qualified Status and Paying Benefits

This chapter describes the duties of a plan administrator in determining the qualified status of domestic relations orders and administering distributions under QDROs. The following areas are addressed:

- ❒ What are the plan administrator's responsibilities in furnishing information to a participant and alternate payee?

- ❒ What measures must a plan administrator take to protect the plan participant's benefits upon receipt of a domestic relations order?

- ❒ What procedures must a plan administrator follow in determining whether a domestic relations order is a QDRO?

ERISA imposes a number of responsibilities on the plan administrator relating to the handling of domestic relations orders. As a plan fiduciary, the administrator is required to discharge these responsibilities prudently and solely in the interest of the plan's participants and beneficiaries. It is the view of the Department that the prudent discharge of a fiduciary's responsibilities with respect to the handling of domestic relations orders, like other areas of plan administration, requires plan administrators to take steps to avoid unnecessary and excessive administrative burdens and costs to the plan. The Department believes that the adoption of procedures and policies designed to facilitate, rather than impede, the timely processing and perfection of domestic relations orders generally will serve to minimize plan burdens and costs attendant to QDRO determinations.

The following questions and answers are intended to provide guidance on the discharge of an administrator's obligations under the QDRO and fiduciary responsibility provisions of ERISA.

Q 2-1: What information is an administrator required to provide a prospective alternate payee before the administrator receives a domestic relations order?

Congress conditioned an alternate payee's right to an assignment of a participant's retirement benefit on the prospective alternate payee's obtaining a domestic relations order that satisfies specific informational and other requirements. It is the view of the Department that Congress therefore intended prospective alternate payees -- spouses, former spouses, children, and other dependents of a participant who are involved in a domestic relations proceeding -- to have access to plan and participant benefit information sufficient to prepare a QDRO. Such information might include the summary plan description, relevant plan documents, and a statement of the participant's benefit entitlements.

The Department believes that Congress did not intend to require prospective alternate payees to submit a domestic relations order to the plan as a prerequisite to establishing the prospective alternate payee's rights to information in connection with a domestic relations proceeding. However, it is the view of the Department that a plan administrator may condition disclosure of such information on a prospective alternate payee's providing information sufficient to reasonably establish that the disclosure request is being made in connection with a domestic relations proceeding.

It is the Department's understanding that many domestic relations orders fail initially to qualify when submitted to the plan because they fail to take into account the plan's provisions or the participant's actual benefit entitlements. Affording prospective alternate payees access to plan and participant information in a timely manner will, in the view of the Department, help drafters avoid making such obvious errors in preparing orders and, thereby, facilitate plan administration. *See* Question 2-5.

[ERISA §§ 206(d)(3)(A) - (C), 404(a); IRC § 414(p)(1) - (3)]

Q 2-2: What are the duties of a plan administrator upon receipt of a domestic relations order by the plan?

Upon receipt of a domestic relations order, the plan administrator is required to promptly notify the affected participant and each alternate payee named in the order of the receipt of the order and to provide a copy of the plan's procedures for determining whether a domestic relations order is a QDRO. Notification should be sent to the address included in the domestic relations order.

The administrator is required to determine whether the order is a QDRO within a reasonable period of time after receipt of a domestic relations order and to promptly notify the participant and each alternate payee of such determination. *See* Question 2-10.

[ERISA § 206(d)(3)(G)(i); IRC § 414(p)(6)(A)]

Q 2-3: Is a plan required to have procedures for determining whether a domestic relations order is qualified?

Yes. Every retirement plan is required to establish written procedures for determining whether domestic relations orders are QDROs and for administering distributions under QDROs.

[ERISA § 206(d)(3)(G)(ii); IRC § 414(p)(6)(B)]

Q 2-4: What requirements must a plan's QDRO procedures meet?

The QDRO procedures must:

- be in writing;
- be reasonable;

- provide that each person specified in a domestic relations order received by the plan as entitled to payment of benefits under the plan will be notified (at the address specified in the domestic relations order) of the plan's procedures for making QDRO determinations upon receipt of a domestic relations order, and

- permit an alternate payee to designate a representative for receipt of copies of notices and plan information that are sent to the alternate payee with respect to a domestic relations order.

[ERISA § 206(d)(3)(G)(ii); IRC § 414(p)(6)]

Q 2-5: Are there *other* matters that should be addressed in a plan's QDRO procedures?

Yes. It is the view of the Department of Labor that a plan's QDRO procedures should be designed to ensure that QDRO determinations are made in a timely, efficient, and cost-effective manner, consistent with the administrator's fiduciary duties under ERISA. The Department believes that unnecessary administrative burdens and costs attendant to QDRO determinations and administration can be avoided with clear explanations of the plan's determination process, including:

- An explanation of the information about the plan and benefits that is available to assist prospective alternate payees in preparing QDROs, such as summary plan descriptions, plan documents, individual benefit and account statements, and any model QDROs developed for use by the plan (*see* Questions 2-1, 2-7);

- A description of any time limits set by the plan administrator for making determinations;

- A description of the steps the administrator will take to protect and preserve retirement assets or benefits upon receipt of a domestic relations order (for example, a description of when and under what

circumstances plan assets will be segregated or benefit payments will be delayed or suspended) (*See* Questions 2-12, 2-13) and

- A description of the process provided under the plan for obtaining a review of the administrator's determination as to whether an order is a QDRO.

It is the view of the Department that the plan administrator's adoption and use of clear QDRO procedures, coupled with the administrator's provision of information about the plan and benefits upon request, will significantly reduce the difficulty and expense of obtaining and administering QDROs by minimizing confusion and uncertainty about the process.

[ERISA §§ 206(d)(3)(G), 206(d)(3)(H), 404(a); IRC §§ 414(p)(6), 414(p)(7)]

Q 2-6: May a plan administrator charge a participant or alternate payee for determining the qualified status of a domestic relations order?

The Department has taken the position that in the context of a defined contribution plan, an administrator may assess reasonable expenses attributable to a QDRO determination against the individual account of the participant who is a party to the domestic relations order. The documents of the plan should be reviewed to determine how plan expenses are allocated.

[ERISA § 404(a); see Field Assistance Bulletin 2003-3 (see Appendix A)]

Q 2-7: May plan administrators provide parties with a model form or forms to assist in the preparation of a QDRO?

Yes. Although they are not required to do so, plan administrators may develop and make available "model" QDRO forms to assist in the

preparation of a QDRO. Such model forms may make it easier for the parties to prepare a QDRO and reduce the time and expenses associated with a plan administrator's determination of the qualified status of an order. Examples of sample language that may be included in such forms are provided in Appendix C.

Plan administrators are required to honor any domestic relations order that satisfies the requirements to be a QDRO. In the view of the Department, therefore, a plan may not condition its determinations of QDRO status on the use of any particular form.

Q 2-8: In determining the qualified status of a domestic relations order, is the administrator required to determine the validity of the order under state domestic relations law?

No. A plan administrator is generally not required to determine whether the issuing court or agency had jurisdiction to issue an order, whether state law is correctly applied in the order, whether service was properly made on the parties, or whether an individual identified in an order as an alternate payee is in fact a spouse, former spouse, child, or other dependent of the participant under state law.

[*See* Advisory Opinion 99-13A (Appendix A); Advisory Opinion 92-17A (Appendix A)]

Q 2-9: Is a plan administrator required to reject a domestic relations order as defective if the order fails to specify factual identifying information that is easily obtainable by the plan administrator?

No. In many cases, an order that is submitted to a plan may clearly describe the identity and rights of the parties, but may be incomplete only with respect to factual identifying information within the plan administrator's

knowledge or easily obtained through a simple communication with the alternate payee or the participant. For example, an order may misstate the plan's name or the names of participants or alternate payees, and the plan administrator can clearly determine the correct names, or an order may omit the addresses of participants or alternate payees, and the plan administrator's records include this information. In such a case, the plan administrator should supplement the order with the appropriate identifying information, rather than rejecting the order as not qualified.

[ERISA §§ 206(d)(3)(C), 206(d)(3)(I); IRC § 414(p)(2); *see* S. Rep. 575, 98th Cong., 2d Sess. at 20]

Q 2-10: How long may the plan administrator take to determine whether a domestic relations order is a QDRO?

Plan administrators must determine whether a domestic relations order is a QDRO within a reasonable period of time after receiving the order. What is a reasonable period will depend on the specific circumstances. For example, a domestic relations order that is clear and complete when submitted should require less time to review than an order that is incomplete or unclear. *See* Question 2-12.

Plans are required to adopt reasonable procedures for determining the qualified status of domestic relations orders. Compliance with such procedures should ensure that determinations of the qualified status of an order take place within a reasonable period of time. Procedures that unduly inhibit or hamper the QDRO determination process will not be considered reasonable procedures. *See* Question 2-4.

[ERISA § 206(d)(3)(G)(i)(II); IRC § 414(p)(6)(A)(ii)]

Q 2-11: What must the plan administrator do during the determination process to protect against wrongly paying retirement benefits to the participant that would be paid to the alternate payee if the domestic relations order had been determined to be a QDRO?

During any period in which the issue of whether a domestic relations order is a QDRO is being determined (by a plan administrator, by a court of competent jurisdiction, or otherwise), ERISA requires that the plan administrator separately account for the amounts that would be payable to an alternate payee under the terms of the order during such period if the order had been determined to be qualified. These amounts are referred to as "segregated amounts." During the period in which the status of a domestic relations order is being determined, the plan administrator must take steps to ensure that amounts that would have been payable to the alternate payee, if the order were a QDRO, are not distributed to the participant or any other person.

The plan administrator's duty to separately account for and to preserve the segregated amounts is limited in time. ERISA provides that the plan administrator must preserve the segregated amounts for not longer than the end of an "18-month period." This "18-month period" does not begin until the first date (after the plan receives the order) that the order would require payment to the alternate payee.

It is the view of the Department that, in order to ensure the availability of a full 18- month protection period, the 18 months cannot begin before the plan receives a domestic relations order. Rather, the "18-month period" will begin on the first date on which a payment would be required to be made under an order *following receipt by the plan*. See Questions 2-12 and 2-13, which discuss how benefits should be treated when determinations on qualified status are made either before or after the beginning of the "18-month period."

[ERISA §§ 206(d)(3)(H), 404(a); IRC § 414(p)(7)]

Q 2-12: What are an administrator's duties with respect to a domestic relations order received by the plan before the beginning of the "18-month period"?

As explained in Question 2-10, a plan administrator must determine whether a domestic relations order is a QDRO within a reasonable period following receipt. In the view of the Department, the "18-month period" during which a plan administrator must preserve the "segregated amounts" (*see* Question 2-11) is not the measure of the reasonable period for determining the qualified status of an order and in most cases would be an unreasonably long period of time to take to review an order.

It is further the view of the Department that, during the determination period, the administrator, as a plan fiduciary, may not permit distributions to the participant or any other person of any amounts that would be payable to the alternate payee if the domestic relations order were determined to be a QDRO. If the domestic relations order is determined to be a QDRO before the first date on which benefits are payable to the alternate payee, the plan administrator has a continuing duty to account for and to protect the alternate payee's interest in the plan to the same extent that the plan administrator is obliged to account for and to protect the interests of the plan's participants. The plan administrator also has a fiduciary duty to pay out benefits in accordance with the terms of the QDRO.

The Department understands that orders that are initially rejected by the plan administrator as not qualified are frequently revised and resubmitted within a short period of time. The Department also recognizes that in some instances plan administrators who reject an order may receive requests from participants for immediate distribution of benefits under circumstances that suggest that the rejected order is being revised and will shortly be resubmitted to the plan. In such circumstances, the plan administrator may be subject to conflicting claims for either paying the benefit or failing to

pay the benefit. The Department suggests that plan administrators may wish to consider the establishment of a process for providing preliminary or interim review of orders, and postponing final determinations for limited periods, to permit parties to correct defects within the 18-month segregation period. Such a process would reduce the likelihood of conflicting claims.

[ERISA §§ 206(d)(3)(H), 404(a)]

Q 2-13: What are an administrator's duties with respect to a domestic relations order received on or after the date on which benefits would be payable to an alternate payee under the order?

Upon receipt of a domestic relations order, the administrator must separately account for and preserve the amounts that would be payable to an alternate payee until a determination is made with respect to the status of the order. *See* Questions 2-11, 2-12. If, within the "18-month period" -- beginning with the date (after receipt of the order by the plan) on which the first payment would be required to be made to an alternate payee under the order -- the plan administrator determines that the order is a QDRO, the plan administrator must pay the segregated amounts to the alternate payee in accordance with the terms of the QDRO. If, however, the plan administrator determines within the "18-month period" that the order is not a QDRO, or if the status of the order is not resolved by the end of the "18-month period," the plan administrator must pay out the segregated amounts to the person or persons who would have been entitled to such amounts if there had been no order. If the order is later determined to be a QDRO, the order will apply only prospectively; that is, the alternate payee will be entitled only to amounts payable under the order after the subsequent determination. *See* Question 2-12.

[ERISA §§ 206(d)(3)(H), 404(a); IRC § 414(p)(7); *but see* H.R. Conf. Rep. No. 841, 99th Cong., 2d Sess. II-858 (describing 1986 amendments to the Retirement Equity Act of 1984, including clarification of the procedures to be followed during the 18-month segregation period for QDRO determinations)]

Q 2-14: What kind of notice is required to be provided by a plan administrator following a QDRO determination?

The plan administrator is required to notify the participant and each alternate payee of the administrator's determination as to whether the order constitutes a QDRO. This notice should be in writing and furnished promptly following a determination.

In the case of a determination that an order is not qualified, the notice should include the reasons for the rejection. It is the view of the Department that, in most instances where there has been a reasonable good faith effort to prepare a qualified domestic relations order, the parties will attempt to correct any deficiencies in the order and resubmit a corrected order for the plan administrator to review. The Department believes that, where a reasonable good faith effort has been made to draft a QDRO, prudent plan administration requires the plan administrator to furnish to the parties the information, advice, and guidance that is reasonably required to understand the reasons for a rejection, either as part of the notification process or otherwise, if such information, advice, and guidance could serve to reduce multiple submissions of deficient orders and therefore the burdens and costs to plans attendant on review of such orders.

The notice of the plan administrator's determination should be written in a manner that can be understood by the parties. Multiple submissions and unnecessary expenses may be avoided by clearly communicating in the rejection notice:

- the reasons why the order is not a QDRO;
- references to the plan provisions on which the plan administrator's determination is based;
- an explanation of any time limits that apply to rights available to the parties under the plan (such as the duration of any protective actions the plan administrator will take); and

- a description of any additional material, information, or modifications necessary for the order to be a QDRO and an explanation of why such material, information, or modifications are necessary.

[ERISA §§ 206(d)(3)(G)(i)(II), 206(d)(3)(I); IRC § 414(p)(6)(A)(ii)]

Q 2-15: What effect does an order that a plan administrator has determined to be a QDRO have on the administration of the plan?

The plan administrator must act in accordance with the provisions of the QDRO as if it were a part of the plan. In particular, if, under a plan, a participant has the right to elect the form in which benefits will be paid, and the QDRO gives the alternate payee that right, the plan administrator must permit the alternate payee to exercise that right under the circumstances and in accordance with the terms that would apply to the participant, as if the alternate payee were the participant.

[ERISA §§ 206(d)(3)(A), 206(d)(3)(E)(i)(III); IRC §§ 401(a)(13)(B), 414(p)(4)(A)(iii)]

Q 2-16: What disclosure rights does an alternate payee have under a QDRO?

ERISA provides that a person who is an alternate payee under a QDRO generally shall be considered a beneficiary under the plan for purposes of ERISA. Accordingly, the alternate payee must be furnished, upon written request, copies of a variety of documents, including the latest summary plan description, the latest annual report, any final annual report, and the bargaining agreement, trust agreement, contract, or other instrument under which the plan is established or operated. The administrator may impose a reasonable charge to cover the cost of furnishing such copies. It is the view of the Department that, at such time as benefit payments to the alternate payee commence under the QDRO, the alternate payee must be treated as a "beneficiary receiving benefits under the plan" and automatically furnished

the summary plan description, summaries of material plan changes, and the plan's summary annual report.

[ERISA §§ 104, 105, 206(d)(3)(J), 404(a); 29 CFR § 2520.104b-1 *et seq.*]

Q 2-17: What happens to the rights created by a QDRO if the plan to which the QDRO applies is amended, merged into another plan, or is maintained by a successor employer?

The rights of an alternate payee under a QDRO are protected in the event of plan amendments, a plan merger, or a change in the sponsor of the plan to the same extent that rights of participants or beneficiaries are protected with respect to benefits accrued as of the date of the event.

[ERISA §§ 204(g), 206(d)(3)(A), 403(c)(1); IRC §§ 401(a)(13)(B), 411(d)(6); *see* Staff of the Joint Committee on Taxation, Explanation of Technical Corrections to the Tax Reform Act of 1984 and Other Recent Tax Legislation, 100th Cong., 1st Sess. (Comm. Print 1987) at 224]

Q 2-18: What happens to the rights created by a QDRO if a plan is terminated?

In the view of the Department, the rights granted by a QDRO must be taken into account in the termination of a plan as if the terms of the QDRO were part of the plan. To the extent that the QDRO grants the alternate payee part of the participant's benefits, the plan administrator, in terminating the plan, must provide the alternate payee with the notification, consent, payment, or other rights that it would have provided to the participant with respect to that portion of the participant's benefits.

[ERISA §§ 206(d)(3)(A), 403(d)]

Q 2-19: What happens to the rights created by a QDRO if a defined benefit plan is terminated and the Pension Benefit Guaranty Corporation becomes trustee of the plan?

The Pension Benefit Guaranty Corporation (PBGC) is a Federal agency that insures pension benefits in most private-sector defined benefit pension plans. It is important to note that not all plans are insured by PBGC and not all plans that terminate become trusteed by PBGC. For example, defined contribution plans (including 401(k) plans) are generally not covered by PBGC's insurance. In addition, most defined benefit plans that terminate have sufficient assets to pay all benefits. PBGC does not trustee these plans. *See* Question 3-4 for a discussion of these basic types of retirement plans.

When an insured plan terminates without enough money to pay all guaranteed benefits, PBGC becomes trustee of the terminating plan and pays the plan benefits subject to certain limits. For instance, PBGC does not pay certain death and supplemental benefits. In addition, benefit amounts and the forms of benefit PBGC pays are limited. PBGC has special rules that apply these guarantee limitations to QDROs. *See* PBGC's booklet, **Qualified Domestic Relations Orders & PBGC**.

For information about a specific domestic relations order or QDRO affecting a plan trusteed by PBGC, write to PBGC QDRO Coordinator, P.O. Box 151750, Alexandria, VA 22315-1750. For information about terminated pension plans that PBGC has trusteed, benefit information with respect to a participant in a PBGC-trusteed plan, or to request a copy of PBGC's booklet, call PBGC's Customer Service Center at 1-800-400-PBGC (7242). The booklet is also available on PBGC's Web site at **www.pbgc.gov**.

Chapter 3
Drafting QDROs

This chapter provides guidance for the process of drafting domestic relations orders that qualify as QDROs. The following areas are addressed:

- What are the most common and useful ways of dividing retirement benefits?
- What are survivor benefits, and why are they important?
- When can an alternate payee receive the benefits assigned by a QDRO?
- In what form will the alternate payee receive the assigned benefits?

Although domestic relations orders that involve retirement plans are issued under and governed by state law, Federal law (ERISA and the Code) and the terms of the relevant retirement plan determine whether these orders can be QDROs. This chapter discusses how to draft orders that will qualify as QDROs while accomplishing the purposes for which the retirement benefits are being divided.

This chapter also discusses the most common methods of dividing retirement benefits under the two separate types of retirement plans: defined benefit plans and defined contribution plans. The following questions and answers emphasize the importance of understanding the nature of a participant's retirement benefits and of making decisions about the assignment of any survivor benefits payable under the retirement plan.

Q 3-1: What is the best way to divide a participant's retirement benefits in a QDRO?

There is no single "best" way to divide retirement benefits in a QDRO. What will be "best" in a specific case will depend on many factors, including the type of retirement plan, the nature of the participant's retirement benefits, and why the parties are seeking to divide those benefits.

In deciding how to divide a participant's retirement benefits in a QDRO, it is also important to consider two aspects of a participant's retirement benefits: the benefit payable under the plan directly to the participant for retirement purposes (referred to here as the "retirement benefit"), and any benefit that is payable under the plan on behalf of the participant to someone else after the participant dies (referred to here as the "survivor benefit"). These two aspects of a participant's retirement benefits are discussed separately in this booklet only in order to emphasize the importance of considering how best to divide retirement benefits.

The following four questions and answers introduce the basic concepts that should inform decisions about drafting QDROs. Question 3-2 explains the scope of assignment permitted by the QDRO provisions; Questions 3-3 and 3-4 relate primarily to the retirement benefit; Question 3-5 describes survivor benefits. Later questions present more specific information about how to draft QDROs.

Q 3-2: How much can be given to an alternate payee through a QDRO?

A QDRO can give an alternate payee any part or all of the retirement benefits payable with respect to a participant under a retirement plan. However, the QDRO cannot require the plan to provide increased benefits (determined on the basis of actuarial value); nor can a QDRO require a plan to provide a type or form of benefit, or any option, not otherwise provided under the plan (with one exception, described in Questions 3-9 and 3-10, for an alternate payee's right to receive payment at the participant's "earliest retirement age"). The QDRO also cannot require the payment of benefits to an alternate payee that are required to be paid to another alternate payee under another QDRO already recognized by the plan.

[ERISA §§ 206(d)(3)(B)(i)(I), 206(d)(3)(D), 206(d)(3)(E); IRC §§ 414(p)(1)(A)(i), 414(p)(3), 414(p)(4); Advisory Opinion 2000-09A (see Appendix A)]

Q 3-3: Why are the reasons for dividing the retirement benefits important?

Generally, QDROs are used either to provide support payments (temporary or permanent) to the alternate payee (who may be the spouse, former spouse or a child or other dependent of the participant) or to divide marital property in the course of dissolving a marriage. These differing goals often result in different choices in drafting a QDRO. This answer describes two common different approaches in drafting QDROs for these two different purposes.

One approach that is used in some orders is to "split" the actual benefit payments made with respect to a participant under the plan to give the alternate payee part of each payment. This approach to dividing retirement benefits is often called the "shared payment" approach. Under this

approach, the alternate payee will not receive any payments unless the participant receives a payment or is already in pay status. This approach is often used when a support order is being drafted after a participant has already begun to receive a stream of payments from the plan (such as a life annuity).

An order providing for shared payments, like any other QDRO, must specify the amount or percentage of the participant's benefit payments that is assigned to the alternate payee (or the manner in which such amount or percentage is to be determined). It must also specify the number of payments or period to which it applies. This is particularly important in the shared payment QDRO, which must specify when the alternate payee's right to share the payments begins and ends. For example, when a state authority seeks to provide support to a child of a participant, an order might require payments to the alternate payee to begin as soon as possible after the order is determined to be a QDRO and to continue until the alternate payee reaches maturity. Alternatively, when support is being provided to a former spouse, the order might state that payments to the alternate payee will end when the former spouse remarries. If payments are to end upon the occurrence of an event, notice and reasonable substantiation that the event has occurred must be provided for the plan to be able to comply with the terms of the QDRO.

Orders that seek to divide a retirement benefit as part of the marital property upon divorce or legal separation often take a different approach to dividing the retirement benefit. These orders usually divide the participant's retirement benefit (rather than just the payments) into two separate portions with the intent of giving the alternate payee a separate right to receive a portion of the retirement benefit to be paid at a time and in a form different from that chosen by the participant. This approach to dividing a retirement benefit is often called the "separate interest" approach.

An order that provides for a separate interest for the alternate payee must specify the amount or percentage of the participant's retirement benefit to be assigned to the alternate payee (or the manner in which such amount or percentage is to be determined). The order must also specify the number of payments or period to which it applies, and such orders often satisfy this requirement simply by giving the alternate payee the right that the participant would have had under the plan to elect the form of benefit payment and the time at which the separate interest will be paid. Such an order would satisfy the requirements to be a QDRO.

Federal law does not require the use of either approach for any specific domestic relations purpose, and it is up to the drafters of any order to determine how best to achieve the purposes for which retirement benefits are being divided. Further, the shared payment approach and the separate interest approach can each be used for either defined benefit or defined contribution plans. *See* Question 3-4 for a discussion of the two basic types of retirement plans. However, it is important in drafting any order to understand and follow the terms of the plan. An order that would require a plan to provide increased benefits (determined on an actuarial basis) or to provide a type or form of benefit, or an option, not otherwise available under the plan cannot be a QDRO. *See* Questions 3-4, 3-6, and 3-7 for further information on dividing retirement benefits under defined benefit and defined contribution plans.

In addition to determining whether or how to divide the retirement benefit, it is important to consider whether or not to give the alternate payee a right to survivor benefits or any other benefits payable under the plan. *See* Question 3-5 for a discussion of survivor benefits.

[ERISA § 206(d)(3)(C)(ii) - (iv); IRC § 414(p)(2)(B) - (D)]

Q 3-4: In deciding how to divide the participant's retirement benefits, why is understanding the type of retirement plan important?

Understanding the type of retirement plan is important because the order cannot be a QDRO unless its assignment of rights or division of retirement benefits complies with the terms of the plan. Parties drafting a QDRO should read the plan's summary plan description and other plan documents to understand what retirement benefits are provided under the plan.

Retirement plans may be divided generally into two types: defined benefit plans and defined contribution plans.

A defined benefit plan promises to pay each participant a specific benefit at retirement. This basic retirement benefit is usually based on a formula that takes into account factors like the number of years a participant works for the employer and the participant's salary. The basic retirement benefit is generally provided in the form of periodic payments for the participant's life beginning at what the plan calls "normal retirement age." This stream of periodic payments is generally known as an "annuity." A participant's basic retirement benefit under a defined benefit plan may increase over time, either before or after the participant begins receiving benefits, due to a variety of circumstances, such as increases in salary or the crediting of additional years of service with the employer (which are taken into account under the plan's benefit formula), or through amendment to the plan's provisions, including some amendments to provide cost of living adjustments.

Defined benefit plans may promise to pay benefits at various times, under certain circumstances, or in alternative forms. Benefits paid at those times or in those forms may have a greater actuarial value than the basic retirement benefit payable by the plan at the participant's normal retirement age. When one form of benefit has a greater actuarial value than another

form, the difference in value is often called a "subsidy." See Appendix C for further discussion of the benefits provided under defined benefit plans.

A defined contribution plan, by contrast, is a type of retirement plan that provides for an individual account for each participant. The participant's benefits are based solely on the amount contributed to the participant's account and any income, expenses, gains or losses, and any forfeitures of accounts of other participants that may be allocated to such participant's account. Examples of defined contribution plans include profit sharing plans (like 401(k) plans), employee stock ownership plans (ESOPs), and money purchase plans. A participant's basic retirement benefit in a defined contribution plan is the amount in his or her account at any given time. This is generally known as the participant's "account balance." Defined contribution plans commonly provide for retirement benefits to be paid in the form of a lump sum payment of the participant's entire account balance. Defined contribution plans by their nature do not offer subsidies.

It should be noted, however, that some defined benefit plans provide for lump sum payments, and some defined contribution plans provide for annuities.

[IRS Notice 97-11, 1997-2 IRB 49 (Jan. 13, 1997) (Appendix C)]

Q 3-5: What are "survivor benefits," and why should a QDRO take them into account?

Federal law requires all retirement plans, whether they are defined benefit plans or defined contribution plans, to provide benefits in a way that includes a survivor benefit for the participant's spouse. The provisions creating these protections are contained in section 205 of ERISA and sections 401(a)(11) and 417 of the Code. The type of survivor benefit that is required by Federal law depends on the type of retirement plan. Plans also may provide for survivor (or "death") benefits that are in addition to those required by Federal law. Participants and alternate payees drafting

a QDRO should read the plan's summary plan description and other plan documents to understand the survivor benefits available under the plan.

Federal law generally requires that defined benefit plans and certain defined contribution plans pay retirement benefits to participants who were married on the participant's "annuity starting date" (this is the first day of the first period for which an amount is payable to the participant) in a special form called a "qualified joint and survivor annuity" (QJSA) unless the participant elects a different form and the spouse consents to that election. When benefits are paid as a QJSA, the participant receives a periodic payment (usually monthly) during his or her life, and the surviving spouse of the participant receives a periodic payment for the rest of the surviving spouse's life upon the participant's death. *See* Appendix C for a description of the QJSA. Federal law also generally requires that, if a married participant with a non-forfeitable benefit under one of these types of plans dies before his or her "annuity starting date," the plan must pay the surviving spouse of the participant a monthly survivor benefit. This benefit is called a "qualified preretirement survivor annuity" (QPSA). Appendix C also describes the QPSA.

Those defined contribution plans that are not required to pay retirement benefits to married participants in the form of a QJSA or QPSA (like most 401(k) plans) are required by Federal law to pay any balance remaining in the participant's account after the participant dies to the participant's surviving spouse. If the spouse gives written consent, the participant can direct that upon the participant's death any balance remaining in the account will be paid to a beneficiary other than the spouse, for example, the couple's children. Under these defined contribution plans, Federal law does not require a spouse's consent to a participant's decision to withdraw any portion (or all) of his or her account balance during the participant's life.

If a participant and his or her spouse become divorced before the participant's annuity starting date, the divorced spouse loses all right to

the survivor benefit protections that Federal law requires be provided to a participant's spouse. If the divorced participant remarries, the participant's new spouse may acquire a right to the Federally mandated survivor benefits. A QDRO, however, may change that result. To the extent that a QDRO requires that a former spouse be treated as the participant's surviving spouse for all or any part of the survivor benefits payable after the death of the participant, any subsequent spouse of the participant cannot be treated as the participant's surviving spouse. For example, if a QDRO awards all of the survivor benefit rights to a former spouse, and the participant remarries, the participant's new spouse will not receive any survivor benefit upon the participant's death. If such a QDRO requires that a defined benefit plan, or a defined contribution plan subject to the QJSA and QPSA requirements, treat a former spouse of a participant as the participant's surviving spouse, the plan must pay the participant's benefit in the form of a QJSA or QPSA unless the former spouse who was named as surviving spouse in the QDRO consents to the participant's election of a different form of payment.

It should also be noted that some retirement plans provide that a spouse of a participant will not be treated as married unless he or she has been married to the participant for at least a year. If the retirement plan to which the QDRO relates contains such a one-year marriage requirement, then the QDRO cannot treat the alternate payee as a surviving spouse if the marriage lasted for less than one year.

In addition, it is important to note that some retirement plans may provide for survivor benefits in addition to those required by Federal law for the benefit of the surviving spouse. Generally, however, the only way to establish a former spouse's right to survivor benefits such as a QJSA or QPSA is through a QDRO. A QDRO may provide that a part or all of such other survivor benefits shall be paid to an alternate payee rather than to the person who would otherwise be entitled to receive such death benefits under the plan. As discussed above (*see*, e.g., Question 3-3), a spouse or

former spouse can also receive a right to receive (as a separate interest or as shared payments) part of the participant's retirement benefit as well as a survivor's benefit.

[ERISA §§ 205, 206(d)(3)(F); IRC §§ 401(a)(11), 414(p)(5), 417; Advisory Opinion 2000-09A (see Appendix A)]

Q 3-6: How may the participant's retirement benefit be divided if the retirement plan is a defined contribution plan?

An order dividing a retirement benefit under a defined contribution plan may adopt either a "separate interest" approach or a "shared payment" approach (or some combination of these approaches). *See* Question 3-3 for a discussion of these two approaches. Orders that provide the alternate payee with a separate interest, either by assigning to the alternate payee a percentage or a dollar amount of the account balance as of a certain date, often also provide that the separate interest will be held in a separate account under the plan with respect to which the alternate payee is entitled to exercise the rights of a participant. Provided that the order does not assign a right or option to an alternate payee that is not otherwise available under the plan, an order that creates a separate account for the alternate payee may qualify as a QDRO.

Orders that provide for shared payments from a defined contribution plan should clearly establish the amount or percentage of the participant's payments that will be allocated to the alternate payee and the number of payments or period of time during which the allocation to the alternate payee is to be made. A QDRO can specify that any or all payments made to the participant are to be shared between the participant and the alternate payee.

In drafting orders dividing benefits under defined contribution plans, parties should also consider addressing the possibility of contingencies

occurring that may affect the account balance (and therefore the alternate payee's share) during the determination period. For example, parties might be well advised to specify the source of the alternate payee's share of a participant's account that is invested in multiple investments because there may be different methods of determining how to derive the alternate payee's share that would affect the value of that share. The parties should also consider how to allocate any income or losses attributable to the participant's account that may accrue during the determination period. If an order allocates a specific dollar amount rather than a percentage to an alternate payee as a shared payment, the order should address the possibility that the participant's account balance or individual payments might be less than the specified dollar amount when actually paid out.

[ERISA §§ 206(d)(3)(C); IRC § 414(p)(2)]

Q 3-7: How may the participant's retirement benefit be divided if the retirement plan is a defined benefit plan?

As indicated earlier, an order may adopt either the shared payment or the separate interest approach (or a combination of the two) in dividing retirement benefits in a defined benefit plan. *See* Question 3-3 for a discussion of these two approaches.

If shared payments are desired, the order should specify the amount of each shared payment allocated to the alternate payee either by percentage or by dollar amount. If the order describes the alternate payee's share as a dollar amount, care should be taken to establish that the payments to the participant will be sufficient to satisfy the allocation, and the order should indicate what is to happen in the event a payment is insufficient to satisfy the allocation. The order must also describe the number of payments or period of time during which the allocation to the alternate payee is to be made. This is usually done by specifying a beginning date and an ending

date (or an event that will cause the allocation to begin and/or end). If an order specifies a triggering event that may occur outside the plan's knowledge, notice of its occurrence must be given to the plan before the plan is required to act in accordance with the order. If the intent is that all payments made under the plan are to be shared between the participant and the alternate payee, the order may so specify.

As discussed in Appendix Cat pages 100-101, a defined benefit plan may provide for subsidies under certain circumstances and may also provide increased benefits or additional benefits either earned through additional service or provided by way of plan amendment. A QDRO that uses the "shared payment" method to give the alternate payee a percentage of each payment may be structured to take into account any such future increases in the benefits paid to the participant. Such a QDRO does not need to address the treatment of future subsidies or other benefit increases, because the alternate payee will automatically receive a share of any subsidy or other benefit increases that are paid to the participant. If the parties do not wish to provide for the sharing of such subsidies or increases, the order should so specify.

If a separate interest is desired for the alternate payee, it is important that the order be based on adequate information from the plan administrator and the plan documents concerning the participant's retirement benefit and the rights, options, and features provided under the plan. *See* Question 2-1. In particular, the drafters of a QDRO should consider any subsidies or future benefit increases that might be available with respect to the participant's retirement benefit. The order may specify whether, and to what extent, an alternate payee is to receive such subsidies or future benefit increases. *See* Appendix Cat pages 100-101 for a discussion of subsidies and possible future increases in a participant's benefits in a defined benefit plan.

[ERISA §§ 206(d)(3)(C), 206(d)(3)(D); IRC §§ 414(p)(2), 414(p)(3)]

Q 3-8: May the QDRO specify the form in which the alternate payee's benefits will be paid?

A QDRO that provides for a separate interest may specify the form in which the alternate payee's benefits will be paid subject to the following limitations: (1) the order may not provide the alternate payee with a type or form of payment, or any option, not otherwise provided under the plan; (2) the order may not provide any subsequent spouse of an alternate payee with the survivor benefit rights that Federal law requires be provided to spouses of participants under section 205 of ERISA (*see* Question 3-5); and (3) (for any tax-qualified retirement plan), the payment of the alternate payee's benefits must satisfy the requirements of section 401(a)(9) of the Code respecting the timing and duration of payment of benefits. In determining the form of payment for an alternate payee, an order may substitute the alternate payee's life for the life of the participant to the extent that the form of payment is based on the duration of an individual's life. As discussed in Appendix C at pages 102-103, however, the timing and forms of benefit available to an alternate payee under a tax-qualified plan may be limited by section 401(a)(9) of the Code.

Alternatively, a QDRO may (subject to the limitations described above) give the alternate payee the right that the participant would have had under the plan to elect the form of benefit payment. For example, if a participant would have the right to elect a life annuity, the alternate payee may exercise that right and choose to have the assigned benefit paid over the alternate payee's life. However, the QDRO must permit the plan to determine the amount payable to the alternate payee under any form of payment in a manner that does not require the plan to pay increased benefits (determined on an actuarial basis).

A plan may by its own terms provide alternate payees with additional types or forms of benefit, or options, not otherwise provided to participants, such as a lump-sum payment option, but the plan cannot prevent a QDRO from assigning to an alternate payee any type or form of benefit, or option, provided generally under the plan to the participant.

[ERISA §§ 206(d)(3)(A), 206(d)(3)(D), 206(d)(3)(E)(i)(III); IRC §§ 401(a)(9), 401(a)(13)(B), 414(p)(3), 414(p)(4)(A)(iii)]

3-9: When can the alternate payee get the benefits assigned under a QDRO?

A QDRO that provides for shared payments must specify the date on which the alternate payee will begin to share the participant's payments. Such a date, however, cannot be earlier than the date on which the plan receives the order. With respect to a separate interest, an order may either specify the time (after the order is received by the plan) at which the alternate payee will receive the separate interest or assign to the alternate payee the same right the participant would have had under the plan with regard to the timing of payment. In either case, a QDRO cannot provide that an alternate payee will receive a benefit earlier than the date on which the participant reaches his or her "earliest retirement age," unless the plan permits payments at an earlier date. Question 3-10 describes how to determine this "earliest retirement age," which is often a date earlier than the earliest date on which the participant would be entitled to receive his or her retirement benefit.

The plan itself may contain provisions permitting alternate payees to receive separate interests awarded under a QDRO at an earlier time or under different circumstances than the participant could receive the benefit. For example, a plan may provide that alternate payees may elect to receive a lump sum payment of a separate interest at any time. As discussed in question 3-8 and in Appendix C at pages 102-103, section 401(a)(9) of the Code may affect when benefits must be paid under tax-qualified retirement plans.

[ERISA §§ 206(d)(3)(C), 206(d)(3)(D), 206(d)(3)(E); IRC §§ 401(a)(9), 414(p)(2), 414(p)(3), 414(p)(4)]

Q 3-10: What is "earliest retirement age," and why is it important?

For QDROs, Federal law provides a very specific definition of "earliest retirement age," which is the earliest date as of which a QDRO can order payment to an alternate payee (unless the plan permits payments at an earlier date). The "earliest retirement age" applicable to a QDRO depends on the terms of the retirement plan and the participant's age. "Earliest retirement age" is the earlier of two dates:

- the date on which the participant is entitled to receive a distribution under the plan, or

- the later of either:

  - the date the participant reaches age 50, or

  - the earliest date on which the participant could begin receiving benefits under the plan if the participant separated from service with the employer.

Drafters of QDROs should consult the plan administrator and the plan documents for information on the plan's "earliest retirement age." The following examples illustrate the concept of "earliest retirement age."

Example 1. The retirement plan is a defined contribution plan that permits a participant to make withdrawals only when he or she reaches age 59½ or terminates from service. The "earliest retirement age" for a QDRO under this plan: is the earlier of (1) when the participant actually terminates employment or reaches age 59½, or (2) the later of the date the participant reaches age 50 or the date the participant could receive the account balance if the participant terminated employment. Since the participant could terminate employment at any time and thereby be able to receive the

account balance under the plan's terms, the later of the two dates described above is "age 50." The "earliest retirement age" formula for this plan can be simplified to read the earlier of: (1) actually reaching age 59½ or terminating employment or (2) age 50 Since age 50 is earlier than age 59½, the "earliest retirement age" for this plan will be the earlier of age 50 or the date the participant actually terminates from service.

Example 2. The retirement plan is a defined benefit plan that permits retirement benefits to be paid beginning when the participant reaches age 65 and terminates employment. It does not permit earlier payments. The "earliest retirement age" for this plan is: the earlier of (1) the date on which the participant actually reaches age 65 and terminates employment, or (2) the later of age 50 or the date on which the participant reaches age 65 (whether he or she terminates employment or not). Because age 65 is later than age 50, the second part of the formula can be simplified to read "age 65" so that the formula reads as follows: the "earliest retirement age" is the earlier of (1) the date on which the participant reaches age 65 and actually terminates or (2) the date the participant reaches age 65. Under this plan, therefore, the "earliest retirement age" will be the date on which the participant reaches age 65.

[ERISA § 206(d)(3)(E); IRC § 414(p)(4)]

Appendix A

Department of Labor Interpretive Guidance

December 4, 1990

Ms. Ellen O. Pfaff
Lane Powell Moss & Miller
3800 Rainier Bank Tower
Seattle, Washington 98101-2647

AO 90-46A
ERISA SEC. 514, 206(d)

Dear Ms. Pfaff:

This responds to your request for an advisory opinion, on behalf of the trustee of the Bruce A. Nordstrom Self-Employed Retirement Plan (Plan), concerning the application of sections 514 and 206(d) of the Employee Retirement Income Security Act of 1974 (ERISA) with respect to the court order described below.[1] **Your submission contains the following facts and representations.**

The Plan is a tax-qualified retirement plan[2] under which benefits are payable upon the participant's retirement or death. The Plan provides that benefits may not be assigned or alienated except in the case of a "qualified domestic relations order." Bruce A. Nordstrom is a Plan participant whose benefit account is not in pay status.

Bruce Nordstrom's wife, Frances W. Nordstrom, died October 5, 1984. Her will was admitted to probate in the superior court for the State of Washington at King County (the Court). Subsequently, the estate of Frances Nordstrom (the Estate) filed a petition asking the Court to require the Plan to divide and segregate that portion of Bruce Nordstrom's benefits which represents the interest of the Estate. You indicate the request was made on the grounds that, inter alia, Frances Nordstrom owned at her death an undivided one-half community interest in Bruce Nordstrom's accrued benefits pursuant to the community property law of the State of Washington and that a court order for such division and segregation of benefits could issue in accordance with section 206(d)(3) of ERISA. The Court granted the petition and entered an order styled "Qualified Domestic Relations Order and Order Dividing Retirement Plan Benefits" (the Court Order).

You request the views of the Department of Labor concerning whether the community property law of the State of Washington is preempted by section 514 of ERISA and whether the Court Order falls within the scope of section 206(d)(3) of ERISA. Section 514(a) of ERISA generally preempts all state laws insofar as they relate to employee benefit plans covered by title I of ERISA. Therefore, a state community property law that considers the pension earned by a married spouse to be community property is preempted under this provision, unless some exception applies.

[1]For convenience, this letter refers to the provisions of section 206(d) of ERISA rather than to the corresponding provisions in sections 401(a)(13)(B) and 414(p) of the Internal Revenue Code, to which your request refers.

[2]You indicated in a telephone conversation with a representative of this Office that the plan has a number of participants and is covered by title I of ERISA.

Section 514(b) of ERISA specifies certain exceptions from the broad preemptive effect of section 514(a). Of those exceptions, only that provided by section 514(b)(7) has relevance to community property laws. Section 514(b)(7) states that preemption under section 514(a) does not apply to "qualified domestic relations orders" within the meaning of ERISA section 206(d)(3)(B)(i).

Section 206(d)(1) of ERISA generally requires pension plans covered by title I of ERISA to provide that plan benefits may not be assigned or alienated. Section 206(d)(3)(A) of ERISA states that section 206(d)(1) applies to an assignment or alienation of benefits pursuant to a "domestic relations order," unless the order is determined to be a "qualified domestic relations order" (QDRO). Section 206(d)(3)(A) further provides that pension plans must provide for payment of benefits in accordance with the applicable requirements of any QDRO.

Section 206(d)(3)(B) of ERISA defines the terms "qualified domestic relations order" and "domestic relations order" for purposes of section 206(d)(3) as follows:

> For purposes of [section 206(d)(3)] —
>
> > (i) the term "qualified domestic relations order" means a domestic relations order—
> >
> > > (I) which creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under a plan, and
> >
> > > (II) with respect to which the requirements of subparagraphs (C) and (D) are met, and
> >
> > (ii) the term "domestic relations order" means any judgment, decree, or order (including approval of a property settlement agreement) which —
> >
> > > (I) relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant, and
> >
> > > (I) is made pursuant to a State domestic relations law (including a community property law) (emphasis added)

The term "alternate payee" is defined by ERISA section 206(d)(3)(K) to mean "any spouse, former spouse, child, or other dependent of a participant who is recognized by a domestic

relations order as having a right to receive all, or a portion of, the benefits payable under a plan with respect to such participant."

Sections 514(b)(7) and 206(d)(3) of ERISA were enacted as part of the Retirement Equity Act of 1984 (REA), which aimed primarily at assuring greater and more equitable opportunity for women working as employees or homemakers to receive private pension income. The legislative history of the QDRO provisions of REA contains numerous statements indicating that Congress was focusing on the division of pension benefits in marital dissolution or dependent support situations. For example, Congressman William Clay described the QDRO provisions during a House floor debate on the legislation as follows:

> Finally, women may be denied their rights to pension benefits by the dissolution of a marriage by divorce, regardless of how many years she served as an economic partner to a man covered by a pension plan. Even in cases in which the State domestic relations court is willing to consider the pension an asset of the marriage and award the ex-wife a share of it, her rights have been thwarted. Pension plans have refused to honor those court orders claiming that they required an impermissible assignment of benefits and were preempted by ERISA.
>
> H.R. 4280 makes it clear that honoring a legitimate State court order awarding an ex-spouse some or all of a worker's pension does not violate the antiassignment clause of ERISA. In addition, the legislation creates an exception from ERISA's broad preemption of State laws for qualified domestic relations orders.[3]

Moreover, the report of the Senate Committee on Finance made specific mention of state community property laws in observing that "[s]everal cases have arisen in which courts have been required to determine whether the ERISA preemption and spendthrift provisions apply to family support obligations (e.g. alimony, separate maintenance, and child support obligations)".[4] The report noted "[t]here is a divergence of opinion among the courts as to whether ERISA preempts State community property laws insofar as they relate to the rights of a married couple to benefits under a pension, etc, plan," [5] and cited two cases in which application of state community property law to pension benefits was at issue in the context of marital dissolution proceedings.[6]

[3]130 Cong. Rec. 13327 (1984).

[4]S. Rep. No 575, 98th Cong., 2d Sess. 18 (1984).

[5]Id. 19.

[6]The cases cited were Stone v. Stone, 632 F. 2d 740 (9th Cir. 1980) and Francis v. United Technology Corp., 458 F. Supp. 84 (N.D. Cal. 1978).

It thus appears Congress generally intended that the QDRO provisions of ERISA would have application in those court proceedings conducted primarily to resolve domestic relations issues. With respect to ERISA section 206(d)(3)(B)(ii)(II), it is the view of the Department of Labor that Congress intended the QDRO provisions to encompass state community property laws only insofar as such laws would ordinarily be recognized by courts in determining alimony, property settlement and similar orders issued in domestic relations proceedings. We find no indication Congress contemplated that the QDRO provisions would serve as a mechanism in which a non-participant spouse's interest derived only from state property law could be enforced against a pension plan.

In the case at hand, the Court Order was issued in a probate proceeding and would recognize an interest in pension benefits of the surviving spouse solely on the basis of the state community property law. Consistent with the views discussed above, it is the opinion of the Department of Labor that the Court Order is not a "domestic relations order" within the meaning of section 206(d)(3)(B)(ii) of ERISA and, therefore, does not constitute a QDRO for purposes of sections 206(d)(3) and 514(b)(7) of ERISA. Accordingly, it is the opinion of the Department of Labor that the Court Order is unenforceable against the Plan.

This letter constitutes an advisory opinion under ERISA Procedure 76-1. Section 10 of the procedure explains the effect of advisory opinions.

Sincerely,

Robert J. Doyle
Director of Regulations
and Interpretations

U.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, D.C. 20210

AUG 21 1992

92-17A
Sec. 206(d)(3)

Ms. Ann E. Neydon
Sachs, Kadushin, O'Hare
Helveston & Waldman, P.C.
1000 Farmer
Detroit, Michigan 48226

Dear Ms. Neydon:

The Internal Revenue Service has referred to us your request for an advisory opinion on behalf of the Cement Masons' Pension Trust Fund (the Plan) concerning the application of the "qualified domestic relations order" (QDRO) exception to the anti-assignment and alienation rules contained in section 206(d)(3) of Title I of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 401(a)(13)(B) and 414(p) of the Internal Revenue Code of 1986 (the Code), to an order from the Circuit Court for the County of Wayne, Michigan. Your submission contains the following facts and representations.

The Plan is qualified under section 401(a) of the Code. The Plan has received a proposed Qualified Domestic Relations Order (the Order) in connection with a domestic relations proceeding in the Circuit Court for the County of Wayne in the State of Michigan. The Order states that X is a Plan participant whose benefit account is not in pay status. As a result of such proceeding, a property division was entered into between X and Y. The property division was executed prior to, and is referenced in, the Order.

According to the terms of the Order, which you enclosed with your letter, the Court approved the property division prior to granting an annulment ab initio of the marriage between the parties. You represent that, at the time of the property division and before the annulment, the parties had been married for 38 years and the marriage had produced six children. Under the Order, and pursuant to the terms of the property division, Y is designated as the "alternate payee" assigned 50% of the participant's accrued benefit as of the date of the Order. The Order further designates Y as the surviving spouse of X. You indicate that Michigan domestic relations law provides for the division of property and the entry of such an order upon the annulment of a marriage.[1]

You request an opinion as to whether a state court correctly ruled that a party to an annulled marriage (1) is a “former spouse” of a participant for purposes of the definition of "alternate payee" in section 206(d)(3)(K) of ERISA, and (2) is designated as a "surviving spouse" pursuant to section 206(d)(3)(F) of ERISA for purposes of the joint and survivor and pre-retirement annuity provisions. In essence, you are requesting an opinion on whether the plan administrator is required to review such rulings as part of the process of determining whether a domestic relations order is qualified under section 206(d)(3) of ERISA.

[1] Section 552.19 of the Michigan statute states that "upon the annulment of a marriage, a divorce from the bonds of matrimony or a judgment of separate maintenance, the court may make a further judgment for restoring to either party the whole, or such parts as it shall deem just and reasonable, of the real and personal estate that shall have come to either party by reason of the marriage, or for awarding to either party the value thereof, to be paid by either party in money." (MCLA 552.19)

Under the Retirement Equity Act of 1984, as amended (REA), the Secretary of Labor has authority to issue regulations interpreting the QDRO provisions in section 206(d)(3) of ERISA, as well as the parallel provisions in sections 401(a)(13)(B) and 414(p) of the Code. To date, the Department has not issued regulations interpreting these provisions. Because your inquiry presents issues on which the answer seems to be clear from the application of these statutory provisions to the facts described, the Department has determined, in accordance with section 5.03 of ERISA Procedure 76-1, 41 Fed. Reg. 36281 (Aug. 27, 1976), that it is appropriate to issue an advisory opinion in this case. For convenience, references to Code sections that parallel provisions of Title I of ERISA are omitted from the following discussion, but may be assumed to be incorporated by reference when the parallel section in Title I of ERISA is cited.

Section 206(d)(1) of ERISA generally requires pension plans covered by Title I to provide that plan benefits may not be assigned or alienated. Section 206(d)(3)(A) of ERISA states that section 206(d)(1) applies to an assignment or alienation of benefits pursuant to a "domestic relations order," unless the order is determined to be a QDRO. Section 206(d)(3)(A) further provides that pension plans must provide for payment of benefits in accordance with the applicable requirements of any QDRO.

Section 206(d)(3)(B) of ERISA defines the terms "qualified domestic relations order" and "domestic relations order" as follows:

> (B) For purposes of [section 206(d)(3)]--
>
> > (i) the term "qualified domestic relations order" means a domestic relations order--
> >
> > > (I) which creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under the plan, and
> >
> > > (II) with respect to which the requirements of subparagraphs (C) and (D) are met, and
> >
> > (ii) the term "domestic relations order" means any judgement, decree, or order (including approval of a property settlement agreement) which--
> >
> > > (I) relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant, and
> >
> > > (II) is made pursuant to a state domestic relations law.

Section 206(d)(3)(C) requires that in order for a domestic relations order to be qualified such order must clearly specify (i) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate payee covered by the order; (ii) the amount or percentage of the participant's benefits to be paid by the plan to each such alternate payee, or the manner in which such amount or percentage is to be determined; (iii) the number of payments or period to which such order applies; and (iv) each plan to which the order applies.

Section 206(d)(3)(D) specifies that a domestic relations order is qualified only if such order does not require (i) the plan to provide any type of benefit, or any option, not otherwise provided by the plan; (ii) the plan to provide increased benefits (determined on the basis of actuarial value); and (iii) the payment of benefits to an alternate payee which are required to be paid to another alternate payee under another order previously determined to be a qualified domestic relations order.

The term "alternate payee" is defined by section 206(d)(3)(K) to mean "any spouse, former spouse, child, or other dependent of a participant who is recognized by a domestic relations order as having a right to receive all, or a portion of, the benefits payable under a plan with respect to such participant."

Section 206(d)(3)(F) of ERISA provides, with respect to the joint and survivor and pre-retirement annuity provisions, that, to the extent provided in any qualified domestic relations order:

> (i) the former spouse of a participant shall be treated as a surviving spouse of such participant for purposes of section 205 (and any spouse of the participant shall not be treated as a spouse of the participant for such purposes), and
>
> (ii) if married for at least 1 year, the surviving spouse shall be treated as meeting the requirements of section 205(f).

Section 206(d)(3)(G) of ERISA requires the plan administrator to determine the qualified status of domestic relations orders received by the plan, and to administer distributions under such qualified orders, pursuant to reasonable procedures established by the plan. Upon receipt of the order, the plan administrator must promptly notify the participant and each alternate payee named in the order of its receipt by the plan and of the plan's procedures for determining the order's qualified status.

Based on the foregoing, when a pension plan receives an order requiring that all or a part of the benefits payable with respect to a participant be distributed to an alternate payee, the plan administrator must determine that the judgment, decree or order is a "domestic relations order" within the meaning of section 206(d)(3)(B)(ii) of ERISA -- i.e., that it relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child or other dependent of the participant, and that it is made pursuant to a State domestic relations law by a State authority with jurisdiction over such matters. Additionally, the plan administrator must determine that the order is qualified under the requirements of section 206(d)(3)(B)(i) of ERISA. It is the view of the Department that the plan administrator is not required by section 206(d)(3) or any other provision of Title I to review the correctness of a determination by a competent State authority that an individual is a "spouse," "former spouse," "child," "other dependent" or “surviving spouse” of the participant under state domestic relations law.[2]

With respect to your submission, you have represented that the Order assigns to former spouse Y, as "alternate payee," 50% of participant X's accrued benefit under the Plan, and designates Y as the "surviving spouse" of X. Further, you indicate that Michigan domestic relations law provides for such a division of property upon the annulment of a marriage. Accordingly, it is the view of the Department that, to the extent the Order was executed by a court of competent jurisdiction pursuant to Michigan domestic relations law, neither the determination under the Order that Y is a "former spouse," and thus meets the requirements to be an "alternate payee" for purposes of section 206(d)(3)(B) of ERISA, nor the determination that Y is a "surviving spouse" for purposes of section 206(d)(3)(F) of ERISA, are required to be reviewed by the plan administrator. The Department expresses no view regarding the qualified status of the domestic relations order in this case.[3]

[2] While the question of whether an order is a qualified domestic relations order under 206(d)(3) of ERISA is a federal question, determinations regarding an individual’s status as a “spouse,” “former spouse,” “child,” “other dependent” or “surviving spouse” for purposes of a QDRO are questions of state law.

[3] As indicated in sections 5.01 and 5.04 of ERISA Procedure 76-1, the Department ordinarily will not issue opinions on matters which are inherently factual in nature, or on the form or effect in operation of particular plan provisions. Accordingly, the Department will not issue advisory opinions as to whether any particular domestic relations order constitutes a QDRO, or whether a specific plan procedure for determining the qualified status of domestic relations orders satisfies the requirements of ERISA section 206(d)(3)(G)(ii).

This letter constitutes an advisory opinion under ERISA Procedure 76-1. Accordingly, it is issued subject to the provisions of the procedure, including section 10 thereof relating to the effect of advisory opinions.

Sincerely,

Robert J. Doyle
Director of Regulations and Interpretations

September 29, 1999

Brian G. Belisle
Oppenheimer Wolff & Donnelly LLP
Plaza VII
45 South Seventh Street
Suite 3400
Minneapolis, Minnesota 55402-1609

1999-13A
ERISA SEC. 206(d)(3)

Dear Mr. Belisle:

This is in response to your request on behalf of the UAL Corporation (UAL) and United Air Lines, Inc. (United) for an advisory opinion. Specifically, you ask how a plan administrator should treat domestic relations orders the plan administrator has reason to believe are "sham" or "questionable" in nature.[1](1)

UAL is a holding company. Its major wholly-owned subsidiary is United. You represent that employees of United participate in three pension plans — an employee stock ownership plan (the ESOP); a 401(k) plan that is a profit sharing plan qualified under section 401(a) of the Code (the 401(k) Plan); and a defined benefit pension plan. The ESOP is a combination leveraged ESOP and non-leveraged stock bonus plan that is qualified under section 401(a) of the Code. Substantially all of the assets in the ESOP are invested in UAL stock.

You represent that the named plan administrator of the ESOP is UAL. UAL has assigned many of its administrative duties under the ESOP, including the duty to establish procedures for determining whether a domestic relations order constitutes a "qualified domestic relations order" (QDRO), to an ESOP Committee consisting of employees of United. The ESOP Committee has delegated to United's Pension Programs Department (Pension Programs) the responsibility of reviewing and determining whether a domestic relations order received by the ESOP Committee is a QDRO within the meaning of section 206(d)(3) of ERISA. Appeals of QDRO determinations are made to the ESOP Committee.

You further represent that the ESOP permits an alternate payee to request the immediate lump sum distribution of any benefits under the plan that are assigned pursuant to the terms of any domestic relations order that the ESOP Committee determines is a QDRO. The ESOP otherwise permits lump sum distributions only following a participant's termination of employment (including by way of the participant's death).

[1]You do not ask and we do not opine as to whether any of the individual domestic relations orders at issue is "qualified" pursuant to section 206(d)(3) of the Employee Retirement Income Security Act of 1974, as amended (ERISA) and section 414(p) of the Internal Revenue Code (Code).

The named plan administrator of the 401(k) Plan is United. United has delegated the authority to control and manage the administration of the 401(k) Plan, including the duty to establish procedures for determining whether a domestic relations order constitutes a QDRO, to a Pension and Welfare Plans Administration Committee (PAWPAC) consisting of employees of United. PAWPAC in turn has delegated to Pension Programs the responsibility for reviewing and determining whether a domestic relations order applying to the 401(k) Plan is a QDRO. Appeals of a QDRO determination are made to PAWPAC. As with the ESOP, the 401(k) Plan permits the immediate distribution of benefits under the plan that are assigned pursuant to the terms of a QDRO. Although an alternate payee may thus receive an immediate lump sum distribution from the 401(k) Plan, participants or beneficiaries are entitled to distributions from the 401(k) plan only following termination of employment (including by way of the participant's death) or upon financial hardship.

You represent that Pension Programs currently has under review 16 domestic relations orders concerning benefits under the ESOP and the 401(k) Plan that Pension Programs believes may be "questionable" or "sham" in nature.[2]

You detail the grounds for Pension Programs' suspicions as to the nature of these domestic relations orders as follows. Pension Programs received within a very short period of time five domestic relations orders from the same lawyer (two of the orders were mailed in the same envelope). Each order related to participants working in United's maintenance facility located in Indianapolis, Indiana. Each of the five orders identically provided for an assignment of 100 percent of the participant's benefit in the ESOP and the 401(k) Plan to an alternate payee. Each order made no provision for any assignment of these participants' benefits in United's defined benefit pension plan. In each of the orders, the alternate payee and participant were shown as having the same address. Despite its suspicions, Pension Programs determined that each of the five orders was qualified because they satisfied the requirements of section 206(d)(3) of ERISA. In Pension Programs' view, these orders differed from other domestic relations orders processed by Pension Programs in that they dealt only with the ESOP and the 401(k) Plan; they provided for assignment of 100 percent of the participant's benefit; and they showed the participant and alternate payee as having the same address.

After its determination that these five domestic relations orders were QDROs, Pension Programs received and reviewed 16 other orders that had unusual characteristics similar to those of the original five orders. These 16 orders similarly provided for a 100 percent assignment of benefits payable under the ESOP and/or the 401(k) Plan, made no mention of the defined benefit pension plan, and specified in most cases that the alternate payee and participant shared the same address. You represent that Pension Programs performed additional investigation in its review

[2]Pension Programs processes between approximately 200 and 300 domestic relations orders per year for all of its qualified retirement plans.

of these 16 domestic relations orders to determine whether they were qualified.[3] While these orders were pending review with Pension Programs, two participants from the Indiana facility called at different times to determine the status of the review of their orders. You indicate that, during those conversations, each participant asserted that his order was not one of the "fraudulent QDROs." You represent that these statements led Pension Programs to heighten its scrutiny of the 16 orders assigning 100 percent of the participant's right to the ESOP and 401(k) benefits.

You further represent that, after beginning its investigation of the 16 domestic relations orders in question, Pension Programs learned of a pamphlet entitled "Retirement Liberation Handbook" that was being distributed by at least one United employee in the Indianapolis, Indiana area.[4](4) The pamphlet advocated, as a method of acquiring a distribution of pension plan benefits before reaching retirement age, that participants and their spouses obtain a divorce for the sole purpose of securing a court order assigning pension plan benefits and then remarry. Such a sham divorce, according to the Liberation Handbook, would enable the participant to obtain direct control over the investment of the participant's pension benefit. The Liberation Handbook also suggested that single employees could go through a sham marriage and subsequent divorce, by paying an individual a percentage of the anticipated pension distribution as compensation for acting as spouse, or could instead quit employment in order to obtain a similar early distribution and later get rehired. The Handbook described in some detail how distributions from pension plans are handled for tax purposes and discussed various options for distributions and investments of the distributions.

After reviewing the Liberation Handbook, Pension Programs determined that all of the 16 orders in question, as well as the original five orders it had previously deemed qualified, had significant similarities to the specific format promoted by the Liberation Handbook. For example, two of the initial five orders requested that distribution be made to an inappropriate account named in the Liberation Handbook.

In addition, all of the orders identified by Pension Programs as questionable relate to the ESOP and 401(k) benefits of employees who, at the time of the order, resided in the Indianapolis area and were in related work groups, and all had a number of common characteristics not typically seen in Pension Programs' review of domestic relations orders. Included in these were rapid remarriage and continued use by the putative alternate payee of United's no-cost travel for spouses.

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[3]You represent that United pays all expenses related to the administration of domestic relations orders and QDROs, including all of the investigative efforts relating to any questionable QDROs and all legal expenses. You state that no plan assets of either the ESOP or the 401(k) Plan have been used directly or indirectly to pay for the expenses of investigating the QDROs at issue here.

[4]The Liberation Handbook apparently first appeared in the classified section of a local advertising exchange.

You represent that Pension Programs engaged local counsel in Indiana to determine whether and to what extent the questionable domestic relations orders might be valid under Indiana law. Indiana counsel opined that, if the orders had been obtained as promoted by the Liberation Handbook, (i) the participant and alternate payee would have committed perjury; (ii) the parties would be in contempt of court; (iii) the order would have been fraudulently obtained; and (iv) if the foregoing could be established to the satisfaction of a judge, the order likely would be vacated by the court.

You have asked for an advisory opinion as to whether, and if so when, a plan administrator may investigate or question a domestic relations order submitted for review to determine whether it is a valid "domestic relations order" under State law for purposes of section 206(d)(3)(B) of ERISA.

Section 206(d)(1) of ERISA generally requires pension plans covered by Title I of ERISA to provide that plan benefits may not be assigned or alienated. Section 206(d)(3)(A) of ERISA states that section 206(d)(1) applies to an assignment or alienation of benefits pursuant to a "domestic relations order" unless the order is determined to be a "qualified domestic relations order" (QDRO). Section 206(d)(3)(A) further provides that pension plans must provide for payment of benefits in accordance with the applicable requirements of any QDRO.

Section 206(d)(3)(B) of ERISA defines the terms "qualified domestic relations order" and "domestic relations order" for purposes of section 206(d)(3) as follows:

> (B) For purposes of [section 206(d)(3)] —
>
> (i) the term "qualified domestic relations order" means a domestic relations order —
>
> (I) which creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under a plan, and
>
> (II) with respect to which the requirements of subparagraphs (C) and (D) are met, and
>
> (ii) the term "domestic relations order" means any judgment, decree, or order (including approval of a property settlement agreement) which —
>
> (I) relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant, and

(II) is made pursuant to a State domestic relations law (including a community property law).

Section 206(d)(3)(C) requires that in order for a domestic relations order to be qualified such order must clearly specify (i) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate payee covered by the order; (ii) the amount or percentage of the participant's benefits to be paid by the plan to each such alternate payee, or the manner in which such amount or percentage is to be determined; (iii) the number of payments or period to which such order applies; and (iv) each plan to which the order applies.

Section 206(d)(3)(D) specifies that a domestic relations order is qualified only if such order does not require (i) the plan to provide any type of benefit, or any option, not otherwise provided by the plan; (ii) the plan to provide increased benefits (determined on the basis of actuarial value); and (iii) the payment of benefits to an alternate payee that are required to be paid to another alternate payee under another order previously determined to be a qualified domestic relations order.

Section 206(d)(3)(G) of ERISA requires the plan administrator to determine the qualified status of domestic relations orders received by the plan and to administer distributions under such qualified orders, pursuant to reasonable procedures established by the plan. In administering QDROs, plan administrators must follow the plan's reasonable procedures, as required under section 206(d)(3)(G), and must assure that the plan pays only reasonable expenses of administering the plan, as required by sections 403(c)(1) and 404(a)(1)(A) of ERISA. In this regard, plan fiduciaries must take appropriate steps to ensure that plan procedures are designed to be cost effective and to minimize expenses associated with the administration of domestic relations orders. See Advisory Opinion 94-32A (Aug. 4, 1994).

When a pension plan receives an order requiring that all or a part of the benefits payable with respect to a participant be paid to an alternate payee, the plan administrator must determine that the judgment, decree or order is a "domestic relations order" within the meaning of section 206(d)(3)(B)(ii) of ERISA — i.e., that it relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child or other dependent of the participant and that it is made pursuant to State domestic relations law by a State authority with jurisdiction over such matters. Additionally, the plan administrator must determine that the order is qualified under the requirements of section 206(d)(3) of ERISA. It is the view of the Department that the plan administrator is not required by section 206(d)(3) or any other provision of Title I to review the correctness of a determination by a competent State authority pursuant to State domestic relations law that the parties are entitled to a judgment of divorce. See Advisory Opinion 92-17A (Aug. 21, 1992). Nevertheless, a plan administrator who has received a document purporting to be a domestic relations order must carry out his or her responsibilities under section 206(d)(3) in a manner consistent with the general fiduciary duties in part 4 of title I of ERISA.

For example, if the plan administrator has received evidence calling into question the validity of an order relating to marital property rights under State domestic relations law, the plan administrator is not free to ignore that information. Information indicating that an order was fraudulently obtained calls into question whether the order was issued pursuant to State domestic relations law, and therefore whether the order is a "domestic relations order" under section 206(d)(3)(C). When made aware of such evidence, the administrator must take reasonable steps to determine its credibility. If the administrator determines that the evidence is credible, the administrator must decide how best to resolve the question of the validity of the order without inappropriately spending plan assets or inappropriately involving the plan in the State domestic relations proceeding. The appropriate course of action will depend on the actual facts and circumstances of the particular case and may vary depending on the fiduciary's exercise of discretion. However, in these circumstances, we note that appropriate action could include relaying the evidence of invalidity to the State court or agency that issued the order and informing the court or agency that its resolution of the matter may affect the administrator's determination of whether the order is a QDRO under ERISA.[5](5) The plan administrator's ultimate treatment of the order could then be guided by the State court or agency's response as to the validity of the order under State law. If, however, the administrator is unable to obtain a response from the court or agency within a reasonable time, the administrator may not independently determine that the order is not valid under State law and therefore is not a "domestic relations order" under section 206(d)(3)(C), but should rather proceed with the determination of whether the order is a QDRO.

This letter constitutes an advisory opinion under ERISA Procedure 76-1, 41 Fed. Reg. 36281 (1976). Accordingly, this letter is issued subject to the provisions of that procedure, including section 10 thereof, relating to the effect of advisory opinions.

Sincerely,

Susan G. Lahne
Acting Chief, Division of
Fiduciary Interpretation
Office of Regulations
and Interpretations

[5]Appropriate action could take other forms, depending on the circumstances and the fiduciary's assessment of the relative costs and benefits, including actual intervention in or initiation of legal proceedings in State court.

July 12, 2000

Gail Inman-Campbell
Walker, Campbell & Campbell
Suite 201 Security Plaza
P.O. Box 1940
Harrison, Arkansas 72602-1940

2000-09A
ERISA Sec. 206(d)(3)

Dear Ms. Inman-Campbell:

This is in response to your request for an advisory opinion under section 206(d)(3) of ERISA. You raise questions regarding the proper treatment of a domestic relations order that assigns to an alternate payee a "company-paid survivor benefit." The terms of the affected pension plan makes this company-paid survivor benefit payable only to a beneficiary designated by the participant from within a limited class of individuals (either the participant's surviving spouse, the participant's minor child or children, or the participant's parent or parents). According to your representations, the survivor benefit in question is not the qualified joint and survivor annuity (QJSA) benefit that is mandated by section 205 of ERISA, but is provided by the plan in addition to the QJSA benefit. Specifically, you ask whether an order requiring the company-paid survivor benefit to be paid to the participant's former spouse, who had been named by the participant as the designated beneficiary under the plan prior to the divorce and as of the date of the participant's retirement, could constitute a "qualified domestic relations order" (QDRO) within the meaning of section 206 (d)(3) of ERISA.

You represent the applicable facts to be as follows. The plan participant was married when he retired from employment. In connection with his retirement, the participant and his then-wife[1] executed the necessary forms to entitle him to begin to receive his retirement benefits under the employer's defined benefit pension plan (the Plan).[2] You further state that the participant elected, with his wife's consent, to decline to receive his benefits under the Plan in the form of a qualified joint and survivor annuity (QJSA) and elected instead to receive a single life annuity. The consent form executed by the participant's wife stated:

> I, [the participant's spouse], hereby acknowledge that I have read the notification on the reverse side regarding post-retirement survivor benefits under the [Plan] and consent to waive my right to receive such benefits as the participant's spouse under the Retirement Equity Act. I also understand that my spouse has authority to specify a beneficiary without my knowledge or consent and that I will not receive any benefit under the Plan unless specified as a beneficiary by my spouse.

[1]Although the participant and his wife were married at the time he retired, they subsequently divorced. For the sake of clarity, and because the change in status is relevant to the analysis, this opinion refers to the participant's former spouse variously (depending on the relevant time period) as either the participant's wife or the participant's former wife.

[2]The Department does not interpret the terms of individual pension plans and has relied, in reaching the conclusions expressed herein, on your representations as to the terms of the Plan and the manner in which those terms are interpreted by the Plan administrator. The Department takes no position regarding the correctness of the representations.

You represent that, in addition to providing the QJSA form of benefit, the Plan provides a company-paid survivor benefit (described below), to which the participant had earned a vested right. This company-paid survivor benefit provides monthly payments to "the surviving spouse of an active employee, the spouse at retirement of a former employee, or a survivor or survivors specified by [the participant] in such a manner as the Board of Benefits and Pensions may prescribe." Plan, Section VI.A (1). You state that the Plan generally limits the categories of survivors whom the participant may designate to receive the company-paid survivor benefit to the following: (1) the employee's spouse (with payments to minor children following the spouse's death); (2) the employee's minor children; or (3) a parent or stepparent of the employee.

In connection with his retirement, the participant designated his wife, together with their then-minor child, as the beneficiaries for the company-paid survivor benefit. That designation has remained in effect unchanged since it was executed. The participant began receiving monthly annuity benefits under the Plan at his retirement and has continued receiving such benefits since that time.

A state court some time later issued a divorce decree dissolving the marriage of the participant and his wife. Thereafter, a Nunc Pro Tunc Supplemental Divorce Decree, (the domestic relations order),(3) [3]described a division of the participant's benefits under the Plan. The domestic relations order assigned to the former wife, as alternate payee, a certain portion of the participant's life annuity payments. The domestic relations order further provided that the former wife "shall be treated as a surviving spouse, as she was the Participant's spouse at his retirement, and that [she] shall receive the employer paid survivor benefits as stated under [the plan]."

After the domestic relations order was submitted to the Plan, the Plan Administrator rejected the domestic relations order as not qualified with respect to the provision of survivor benefits, stating:

> The order attempts to force the Plan to provide a type or form of benefit not otherwise available under the Plan. As explained in previous determination reports, there are no survivor benefits available for any alternate payee. There are no survivor benefits available for [the participant's ex-wife]. The court cannot award the Company-paid survivor benefit to [the participant's ex-wife] because she is not a Plan-qualified beneficiary. The court cannot award a non-existent benefit to an alternate payee.
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> * * * * *
>
> At his retirement, [the participant] designated his spouse, [the participant's former wife], as the beneficiary for the Company-paid survivor benefit. Pursuant to the terms of the Plan, the Company-paid survivor benefit can be paid only to a Plan- qualified beneficiary — spouse, minor children, parent, or stepparent, not a former spouse. At

[3]An earlier order that had purported to assign the right of a surviving spouse to receive survivor benefits in the form of the qualified joint and survivor annuity (QJSA) under section 205 of ERISA (section 401(a)(11) of the Internal Revenue Code) to the participant's former wife was rejected by the Plan as not qualified because the former wife had validly consented to the waiver of those rights. You represent that the former wife does not dispute that she properly waived her right under federal law to receive survivor benefits in the form of a QJSA.

> the time of his retirement, [the participant] designated his spouse and a minor child to receive the Company-paid survivor benefit. During the remaining 10+ years that the parties remained married, [the participant] controlled the beneficiary designation for the Company-paid survivor benefit. At any time during the remainder of the marriage, [the participant] could change the beneficiary to any other Plan-qualified beneficiary or to no one without [the participant's former wife's] consent.

(Emphasis original).

You ask whether the Plan is correct in concluding that, in ordering the company-paid survivor benefit to be paid to the participant's former wife, the domestic relations order would require the Plan to provide a "type or form of benefit, or [an] option not otherwise provided" under the Plan, which is not permitted under section 206(d)(3)(D)(i) of ERISA. As explained below, it is the view of the Department that the Plan erred in reaching this conclusion.

Section 206(d)(1) of ERISA generally requires pension plans covered by Title I of ERISA to provide that plan benefits may not be assigned or alienated. Section 206(d)(3)(A) of ERISA states that section 206(d)(1) applies to an assignment or alienation of benefits pursuant to a "domestic relations order," unless the order is determined to be a "qualified domestic relations order." Section 206(d)(3)(A) further provides that pension plans must provide for payment of benefits in accordance with the applicable requirements of any QDRO.

Section 206(d)(3)(B) of ERISA defines the terms "qualified domestic relations order" and "domestic relations order" for purposes of section 206(d)(3) as follows:

> (B) For purposes of [section 206(d)(3)] —
>
> (i) the term "qualified domestic relations order" means a domestic relations order —
>
> (I) which creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under a plan, and
>
> (II) with respect to which the requirements of subparagraphs (C) and (D) are met, and
>
> (ii) the term "domestic relations order" means any judgment, decree, or order (including approval of a property settlement agreement) which —
>
> (I) relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant, and

(II) is made pursuant to a State domestic relations law (including a community property law).

Section 206(d)(3)(D) specifies that a domestic relations order is qualified only if such order does not require (i) the plan to provide any type of benefit, or any option, not otherwise provided by the plan; (ii) the plan to provide increased benefits (determined on the basis of actuarial value); and (iii) the payment of benefits to an alternate payee which are required to be paid to another alternate payee under another order previously determined to be a qualified domestic relations order.

Section 206(d)(3)(F) of ERISA provides, with respect to the joint and survivor and pre- retirement annuity provisions in ERISA, that, "[t]o the extent provided in any qualified domestic relations order":

(i) the former spouse of a participant shall be treated as a surviving spouse of such participant for purposes of section 205 (and any spouse of the participant shall not be treated as a spouse of the participant for such purposes), and

(ii) if married for at least 1 year, the surviving spouse shall be treated as meeting the requirements of section 205(f).

It is our view that section 206(d)(3)(F) does not, in itself, limit the scope of the survivor benefits that may be assigned to an alternate payee pursuant to section 206(d)(3)(B). Rather, the general scope of permissible assignment is defined by section 206(d)(3)(B) itself, as limited by sections 206(d)(3)(C) and 206(d)(3)(D).[4] Section 206 (d)(3)(B) provides broadly for the possibility of assigning not merely "benefits payable to a participant," but "all or a portion of the benefits payable with respect to a participant under a plan." In using this particular language, Congress made clear that the QDRO provisions are intended to enable State courts or agencies to assign any and all benefits payable under a plan that a participant had earned through employment.

Further, any assignment effected by a QDRO necessarily has the effect of requiring the substitution of an alternate payee for the individual (participant or beneficiary) who would otherwise be entitled to receive the benefit under the terms of the plan in question. The Plan's conclusion that such a substitution would require the Plan to provide a "type or form of benefit, or any option, not otherwise provided" under the Plan, in violation of section 206(d)(3)(D), thus, proves too much. Such an argument would invalidate any assignment of benefits pursuant to a domestic relations order.

[4]Section 206(d)(3)(F) provides an additional right that may be assigned to an alternate payee: the right to be treated as if the divorce had not occurred with respect to the survivor rights created by section 205 of ERISA. The section 205 rights include, but extend beyond, the right to receive the survivor portion of the joint and survivor annuity form of benefit payment that must be provided as the normal form of payment under a plan subject to section 205. Section 206(d)(3)(E) further permits alternate payees to be afforded the right to receive benefit payments as of a participant's "earliest retirement age," rather than when the participant is entitled to receive benefit payments.

In this case, the alternate payee was the individual actually designated by the participant as his beneficiary to receive the company-paid survivor benefit. At his retirement, and until their subsequent divorce, the alternate payee was also within the class of individuals expressly entitled under the terms of the Plan to be named as beneficiary. The order did no more than preserve the alternate payee's status as a spouse with respect to the company-paid survivor benefit when the divorce would otherwise have altered that status. The assignment effected by the order, thus, would not require the Plan to provide a type or form of benefit, or an option not otherwise provided under the Plan. It is the view of the Department that, under the circumstances of this case as you have described them, the plan administrator erred in concluding that an order that named a participant's former spouse as beneficiary for the company-paid survivor benefit would violate the limitations imposed by section 206(d)(3)(D) and therefore could not constitute a QDRO.[5]

This letter constitutes an advisory opinion under ERISA Procedure 76-1, 41 Fed. Reg. 36281 (1976). Accordingly, this letter is issued subject to the provisions of that procedure, including section 10 thereof, relating to the effect of advisory opinions.

Sincerely,

Louis Campagna
Chief, Division of
Fiduciary Interpretations
Office of Regulations
and Interpretations

[5]A domestic relations order, nonetheless, could not be deemed to be qualified if it assigned benefits that have already been paid or have been validly waived under a plan. For example, if an alternate payee has validly waived QJSA rights, as the participant's former wife apparently did when the participant retired, a subsequently issued domestic relations order could not require a plan to provide QJSA rights to the alternate payee.

June 1, 2001

Lee Sapienza
Chief, Bureau of Policy and Planning
Division of Child Support Enforcement
Office of Temporary and Disability Assistance
40 North Pearl Street
Albany, NY 12243-0001

2001-06A
ERISA Sec. 206(d)(3)

Dear Mr. Sapienza:

This is in response to your request for guidance regarding the qualified domestic relations order (QDRO) provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA).[1](1) In particular, you ask whether an income withholding notice issued by the New York State Office of Temporary and Disability Assistance, Division of Child Support Enforcement (DCSE), or a county child support enforcement agency operating under DCSE guidelines, is a judgment, decree, or order within the meaning of section 206(d)(3)(B)(ii) of ERISA.

DCSE is a state agency that administers the programs under Part D of Title IV of the Social Security Act (Title IV-D), generally known as the Child Support Enforcement (CSE), or IV-D, program, for the State of New York. The Federal Office of Child Support Enforcement (OCSE), Department of Health and Human Services, has the responsibility to establish standards for state IV-D agencies, and manages the distribution of federal funding to the state IV-D agencies.

Section 466(a) of the Social Security Act (the act) requires that, as a condition for receiving federal funding under Title IV-D, states have procedures to effectuate withholding from the income of obligors amounts payable as child support in cases that are subject to enforcement by the state. Section 466(b) of the act prescribes procedures that the states must provide for with respect to such income withholding. That section also defines income for purposes of the withholding requirements to include periodic payments due to an individual pursuant to a pension or retirement program. You represent that state IV-D agencies, including DCSE, routinely issue income withholding notices pursuant to federal and state law to enforce child support orders against obligor parents. The child support orders are made pursuant to state family or domestic relations law. The income withholding notices may seek to enforce the child support obligation from various sources of income, including benefits due to a participant in a pension plan.

You represent that notices issued by DCSE and county child support enforcement agencies are frequently determined not to be QDROs by plan administrators. You represent that these plan administrators contend that an income withholding notice is not a judgment, decree, or order, and

[1]References to the Internal Revenue Code sections that parallel the provisions of section 206(d)(3) of ERISA (the QDRO provisions) are omitted from the following, but may be assumed to be incorporated by reference when the parallel provision of section 206(d)(3) is cited.

therefore not a domestic relations order as defined in section 206(d)(3)(B)(ii) of ERISA. As a result, when a pension plan rejects an income withholding notice, DCSE or the county child support enforcement agency must obtain a court order requiring the plan to withhold the necessary child support payments, which order then generally will be accepted as a QDRO by plan administrators.

Section 206(d)(1) of ERISA generally requires that benefits provided under a pension plan may not be assigned or alienated. Section 206(d)(3)(A) of ERISA provides that the anti- assignment and alienation provisions of section 206(d)(1) apply to the assignment or alienation of benefits pursuant to a domestic relations order, unless the order is determined to be a qualified domestic relations order. Section 206(d)(3)(A) further provides that pension plans must provide for the payment of benefits in accordance with the applicable requirements of any QDRO.

Section 206(d)(3)(B) of ERISA defines the term qualified domestic relations order for purposes of section 206(d)(3) as a domestic relations order which creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under a plan, and which meets the requirements of section 206(d)(3)(C) and (D).[2](2)

The term domestic relations order is defined in section 206(d)(3)(B)(ii) as any judgment, decree, or order (including approval of a property settlement agreement) which relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant, and is made pursuant to a state domestic relations law (including a community property law).

The term alternate payee is defined by ERISA section 206(d)(3)(K) to mean any spouse, former spouse, child or other dependent of a participant who is recognized by a domestic relations order as having a right to receive all, or a portion of, the benefits payable under a plan with respect to such participant.

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[2]Section 206(d)(3)(C) provides that in order for a domestic relations order to be qualified, the order must clearly specify (i) the name and last known mailing address (if any) of the participant and the name and mailing address of each alternate payee covered by the order; (ii) the amount or percentage of the participant's benefits to be paid by the plan to each such alternate payee, or the manner in which such amount or percentage is to be determined; (iii) the number of payments or period to which such order applies; and (iv) each plan to which the order applies.

Section 206(d)(3)(D) specifies that a domestic relations order is not qualified if it requires: (i) the plan to provide any type of benefit, or any option, not otherwise provided by the plan; (ii) the plan to provide increased benefits (determined on the basis of actuarial value); or (iii) the payment of benefits to an alternate payee which are required to be paid to another alternate payee under another order previously determined to be a qualified domestic relations order. Section 206(d)(3)(E) provides that an order may not provide that an alternate payee receive a benefit earlier than the date on which the participant reaches his or her earliest retirement age, unless the plan permits payments at an earlier date. Earliest retirement age is defined as the earlier of: (1) The date on which the participant is entitled to receive a distribution under the plan, or (2) the later of (a) the date the participant reaches age 50 or (b) the earliest date on which the participant could begin receiving benefits under the plan if the participant separated from service with the employer.

Section 206(d)(3)(G) of ERISA requires the plan administrator to determine whether a domestic relations order received by the plan is qualified, and to administer distributions under such qualified orders, pursuant to reasonable procedures established by the plan.

When a pension plan receives an order requiring that all or part of the benefits payable with respect to a participant be distributed to an alternate payee, the plan administrator must determine that the judgment, decree, or order is a domestic relations order within the meaning of section 206(d)(3)(B)(ii) of ERISA - i.e., that it relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of the participant, and that it is made pursuant to a state domestic relations law by a state authority with jurisdiction over such matters. Additionally, the plan administrator must determine that the order is qualified under the requirements of section 206(d)(3)(B)(i) of ERISA.

It is the view of the department that an income withholding notice issued by DCSE or county child support enforcement agencies (as described in your submission) as part of the state's IV-D program, is a domestic relations order as defined in section 206(d)(3)(B)(ii) of ERISA. The notice relates to the provision of child support to a child of a participant in a pension plan, enforces a child support order that is made pursuant to state family or domestic relations law, and is made by DCSE or a county child support enforcement agency, which have jurisdiction over child support matters. We note in particular that section 206(d)(3)(B)(ii) does not specify that in order for a judgment, decree, or order to be a domestic relations order for the purposes of section 206(d)(3) that it must be issued by a court.

While a withholding notice issued by DCSE may constitute a domestic relations order for purposes of section 206(d)(3) of ERISA, the administrator of a pension plan that receives such a notice is still obligated to determine whether the notice is a qualified domestic relations order as defined in section 206(d)(3)(B). Whether any notice issued by the state, including the Order/Notice To Withhold Income For Child Support (the form developed by OCSE that state IV-D agencies are required to use to enforce child support obligations), satisfies the requirements of section 206(d)(3)(C) and (D) is an inherently factual question on which the department is unable to opine.

This letter constitutes an advisory opinion under ERISA Procedure 76-1. Accordingly, it is issued subject to the provisions of the procedure, including section 10 thereof relating to the effect of advisory opinions.

Sincerely,

Louis Campagna
Chief, Division of Fiduciary
Interpretations
Office of Regulations
and Interpretations

June 7, 2002

Alsee McDaniel, Director
Division of Child Support Enforcement
Department of Human Services
750 North State Street
Jackson, MS 39202

2002-03A
ERISA Sec. 206(d)

Dear Mr. McDaniel:

This is in response to your request for an advisory opinion concerning the application of section 206(d) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), with respect to the Mississippi Department of Human Services, Division of Child Support Enforcement (DCSE). Your submission contains the following facts and representations.

DCSE is a state agency that administers the programs under Part D of Title IV of the Social Security Act (Title IV-D), generally known as the Child Support Enforcement (CSE), or IV-D, program, for the State of Mississippi. The Federal Office of Child Support Enforcement (OCSE), Department of Health and Human Services, has the responsibility to establish standards for state IV-D agencies, and manages the distribution of Federal funding to the IV-D agencies.

Like other IV-D agencies, DCSE collects child support both for custodial parents who are receiving economic assistance from the state and for those who are not receiving such assistance, but have applied for the agencys services in collecting support payments. DCSE distributes the support payments that it collects on behalf of the custodial parent as follows. If the custodial parent has a public assistance arrearage[1] and is no longer receiving public assistance, DCSE transmits all child support payments it receives to the custodial parent as current child support payments plus any existing child support arrearage before any of the payment is applied to the public assistance arrearage. If the custodial parent has a public assistance arrearage and is currently receiving public assistance, DCSE applies the payments it receives first to the public assistance arrearage and transmits any remaining funds to the custodial parent as current child support payments. If the custodial parent is not receiving public assistance and has no public assistance arrearage, then DCSE transmits the entire payment to the custodial parent. In all cases, DCSE receives the child support payments, deposits them in its own account, and distributes a check representing the child support payment (minus any public assistance arrearages, if applicable) to the custodial parent.

Section 206(d)(1) of ERISA generally requires pension plans subject to Title I to provide that plan benefits may not be assigned or alienated. Section 206(d)(3)(A) provides an exception to the general rule

[1]Pursuant to the IV-D program, State laws provide that a custodial parent who receives public assistance from a State is deemed to assign to the State any right or claim to child support payments that the non-custodial parent is obligated to make, but has not made, to the extent of the owed child support payments plus the State's costs incurred in collecting such support payments. These public assistance payments are considered public assistance arrearages that are owed to the State IV-D agency. In such situations, the public assistance is, essentially, an advance by the State of the child support obligations of the non-custodial parent to the extent of nonpayment, and the retention by the State of all or a portion of the support payments subsequently secured from the non-custodial parent is reimbursement of such advances.

for the creation, assignment or recognition of a right to any benefit payable with respect to a participant pursuant to a qualified domestic relations order (QDRO). Section 206(d)(3)(A) further requires that pension plans must provide for the payment of benefits in accordance with the applicable terms of any QDRO. Section 206(d)(3) describes the conditions that a domestic relations order must satisfy in order to be a QDRO, as well as additional rules regarding a plan administrator's determination of whether a domestic relations order is a QDRO, how benefits are to be administered pursuant to a QDRO, and definitions of certain terms used in section 206(d)(3).

Among other things, section 206(d)(3)(B) provides that a domestic relations order that creates or recognizes an alternate payee's right to, or assigns to the alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under a plan, and complies with the requirements of section 206(d)(3)(C) and (D) is a QDRO. A domestic relations order is defined as any judgment, decree, or order that relates to, among other things, the provision of child support to a child of a participant. Alternate payee is defined in section 206(d)(3)(K) to mean any spouse, former spouse, child, or other dependent of a participant who is recognized by a domestic relations order as having a right to receive all, or a portion of, the benefits payable under a plan with respect to such participant.

You ask whether, under the circumstances described above, DCSE may be considered an alternate payee within the meaning of section 206(d)(3)(K) of ERISA, or, in the alternative, whether a domestic relations order that requires a pension plan to make payments to DCSE on behalf of any alternate payee named in the order may be a QDRO.

You argue that in cases in which the custodial parent received public assistance due, at least in part, to the non-custodial parent's nonpayment of ordered child support prior to the issuance of a QDRO, permitting the IV-D agency to be an alternate payee assures that such amounts are returned to state and federal governments when child support payments are made pursuant to the QDRO. In addition, you maintain that public policy favors allowing IV-D agencies to be alternate payees so that reliable records of all child support payments can be kept.

Section 206(d)(3)(K) of ERISA defines the classes of persons who may be alternate payees for purposes of the QDRO provisions. This provision is part of an exception to ERISA's general rule that benefits due to a participant from a pension may not be assigned or alienated, and thus is to be read narrowly. In the opinion of the Department, an alternate payee cannot be anyone other than one of the persons identified in section 206(d)(3)(K), i.e., a spouse, former spouse, child, or other dependent of a participant in a pension plan. Therefore, DCSE cannot be an alternate payee.

However, the Department recognizes that circumstances may arise that will necessitate another person's acting on behalf of an alternate payee, such as if an alternate payee is a minor or is legally incompetent. In such cases, a domestic relations order that requires that the plan make payment to someone with legal responsibility for the alternate payee, such as a guardian or party acting in loco parentis in the case of such child, or a trustee as agent for the alternate payee, may still be a QDRO.[2] You state that, while DCSE's relationship to a child does not rise to the level of a court-appointed guardian

[2]See, Staff of the Joint Committee on Taxation, Explanation of Technical Corrections to the Tax Reform Act of 1984 and Other Recent Tax Legislation, 100th Cong., 1st Sess. (Comm. Print 1987) at 222.

ad litem or to the fiduciary level of a trustee, DCSE is charged, by federal and state law, to act in the best interests of each child for which it is acting. DCSE is obligated by law to establish a non-custodial parent's child support obligation, to secure and collect child support payments from any person who is legally liable for such support, and to disburse support payments to the custodial parent. DCSE is authorized to use any method available under state law to establish and enforce a parent's support obligations. You therefore contend that DCSE has essentially the same level of responsibility as a guardian or trustee with respect to child support payments, since it is legally obligated to act on the child's behalf, and any child support received goes to the custodial parent on behalf of the child.

It appears that DCSE, in the circumstances you describe, acts as an agent for the child on whose behalf it is acting. The agency receives funds from a pension plan in which the obligor is a participant, and forwards all of those funds to the alternate payee, or the alternate payee's custodial parent, except for the reimbursement to DCSE of public assistance arrearages," which, as noted above, represent advances by the state to the custodial parent of unpaid support obligations. Under these circumstances, it is the opinion of the Department that the fact that a domestic relations order names DCSE as the party to whom payments are to be made on behalf of an alternate payee, would not constitute grounds on which a plan administrator could find the order not to be qualified.

This letter constitutes an advisory opinion under ERISA Procedure 76-1 (41 Fed. Reg. 36281, August 27, 1976). Accordingly, this letter is issued subject to the provisions of the procedure, including section 10 relating to the effect of advisory opinions.

Sincerely,

Louis Campagna
Chief, Division of Fiduciary
Interpretations
Office of Regulations
and Interpretations

cc: Darrell Baughn

February 17, 2004

Terry-Lynne Lastovich
Dorsey & Whitney LLP
50 South Sixth Street, Suite 1500
Minneapolis, MN 55402-1498

2004-02A
ERISA Sec. 206(d)(3)

Dear Ms. Lastovich:

This is in response to your request on behalf of Northwest Airlines, Inc. Retirement Plan for Pilot Employees (the Plan) for an advisory opinion under section 206(d) of Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you ask whether a domestic relations order that changes a prior assignment of benefits to an alternate payee to reduce the amount assigned to the alternate payee may be a "qualified domestic relations order" (QDRO) within the meaning of section 206(d)(3) of ERISA.

You represent that this question arises out of a divorce and property settlement involving a now-retired employee of Northwest Airlines, Inc. (the participant) and his former spouse (the alternate payee). The participant has earned a vested pension benefit under the Plan, which is a defined benefit pension plan. Northwest Airlines, Inc. (Northwest) sponsors and is the administrator of the Plan.

In 1997, while the participant was still actively employed, the Plan received a domestic relations order, dated April 3, 1997, that assigned to the alternate payee a percentage of the participant's pension benefits (the 1997 Order). The 1997 Order was issued by the District Court of the First Judicial District, Family Court Division, County of Dakota, State of Minnesota. In accordance with its procedures, the Plan reviewed the order, determined it to be a QDRO, and so informed both the participant and the alternate payee on August 27, 1997.

In November 2000, while the participant was still actively employed, the participant notified the Plan that both he and the alternate payee desired to modify the assignment reflected in the QDRO to reduce the portion of the participant's benefits that would be paid in the future to the alternate payee. The participant sought the Plan's advice on how to make such a change. The Plan advised the alternate payee and the participant that it would not consider an order that purported to reduce the assignment already made under a previously recognized QDRO to be permissible.

Nonetheless, on June 6, 2002, the participant submitted to the Plan a second domestic relations order, dated June 4, 2002 (the 2002 Order). The 2002 Order was also issued by the District Court of the First Judicial District, Family Division, County of Dakota, State of Minnesota. This order stated that the parties to the divorce were "in agreement" that the QDRO provisions of the 1997 Order should be altered and therefore ordered that those 1997 QDRO provisions were "deleted." The 2002 Order set forth new provisions for a different (and smaller) assignment to the alternate payee.

During the course of its review of the 2002 Order, the Plan expressed its doubts as to whether such a reduction in the amount assigned could be effected by a QDRO and requested both participant and alternate payee to provide "a written explanation of why this amended order should or should not

be reviewed as a qualified domestic relations order." These parties declined to offer argument on this issue and continued to assert that the 2002 Order expressed their consensus on how the participant's benefits should be divided between them.

In September 2002, before the Plan had issued a determination on the qualified status of the 2002 Order, the participant retired, and Northwest began paying benefits to both the participant and the alternate payee under the terms of the 1997 Order.

On November 15, 2002, the Plan sent a letter to the participant, setting forth its "decision" that the 2002 Order was not qualified, based upon its view that a subsequent order cannot reduce the benefits awarded to an alternate payee under a previous domestic relations order recognized by the Plan as a QDRO. This letter set forth the following additional determinations: (1) the 2002 Order is "provisionally" determined not to be a QDRO; (2) the 1997 Order continues in full force and effect; (3) the Plan has requested an advisory opinion from the Department of Labor (the Department) on whether an order that "takes away" benefits previously assigned to an alternate payee can be a QDRO; and (4) pending issuance of the advisory opinion, the Plan will continue to pay out benefits in accordance with the 1997 Order. The letter further advised the participant that, if the Department opined that the 2002 Order cannot be a QDRO, the Plan's determination would become "final." The letter further stated that if the Department opined that the 2002 Order could be a QDRO "even though it 'takes away' a benefit previously awarded" to the alternate payee, it would then seek reimbursement of any "overpayments" made to the alternate payee based on the 1997 Order. If the alternate payee did not return the "overpayments" the Plan would withhold future payments to the alternate payee until the "overpayments" were recovered.

This request for an advisory opinion ensued. In the context of these facts, you seek guidance on whether the 2002 Order, which purported to reduce the amount of the participant's benefits that are assigned to the alternate payee, could qualify as a QDRO within the meaning of section 206(d)(3) of ERISA.

Under section 206(d)(3) of ERISA, the plan administrator is the party to whom an initial determination of the qualified status of an order is entrusted. The Department generally does not provide advisory opinions addressing this question because making such a determination necessarily requires an interpretation of the specific provisions of a plan and application of those provisions to specific facts, including the nature and amount of a participant's pension benefits. Nonetheless, the Department believes it is appropriate to provide guidance under section 206(d)(3) on the narrow issue you have presented of whether a subsequent domestic relations order that alters or modifies a qualified domestic relations order involving the same participant and alternate payee may itself be qualified and therefore supercede the previous order. In providing this guidance, however, the Department takes no position on whether any particular order described in this letter is or is not a "qualified domestic relations order" within the meaning of section 206(d)(3) of ERISA.

Section 206(d)(1) of ERISA generally requires pension plans covered by Title I of ERISA to provide that plan benefits may not be assigned or alienated. Section 206(d)(3)(A) of ERISA states that section 206(d)(1) applies to any assignment or alienation of benefits made pursuant to a "domestic relations order," unless the order is determined to be a "qualified domestic relations order." Section 206(d)(3)

(A) further provides that pension plans must provide for the payment of benefits in accordance with the applicable requirements of any order that is determined to be a "qualified domestic relations order." The grounds on which the plan administrator must judge the status of an order that purports to assign benefits are set forth in the specific subparagraphs of section 206(d)(3).

Subparagraph (B) of section 206(d)(3) of ERISA defines the terms "qualified domestic relations order" and "domestic relations order" for purposes of section 206(d)(3) as follows:

(B) For purposes of [section 206(d)(3)] —

(i) the term "qualified domestic relations order" means a domestic relations order —

(I) which creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under a plan, and

(II) with respect to which the requirements of subparagraphs (C) and (D) are met, and

(ii) the term "domestic relations order" means any judgment, decree, or order (including approval of a property settlement agreement) which —

(I) relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant, and

(II) is made pursuant to a State domestic relations law (including a community property law).

Subparagraphs (C) and (D) of section 206(d)(3) of ERISA contain both positive and negative requirements for qualification of a domestic relations order. Subparagraph (C) specifies that, in order for a domestic relations order to be qualified, such order must clearly specify (i) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate payee covered by the order; (ii) the amount or percentage of the participant's benefits to be paid by the plan to each such alternate payee, or the manner in which such amount or percentage is to be determined; (iii) the number of payments or period to which such order applies; and (iv) each plan to which the order applies.

Subparagraph (D) provides that an order cannot be qualified if it either (i) requires the plan to provide any type of benefit, or any option, not otherwise provided by the plan; (ii) requires the plan to provide increased benefits (determined on the basis of actuarial value); or (iii) requires the plan to pay benefits to an alternate payee that are required to be paid to another alternate payee under another order previously determined to be a qualified domestic relations order.

A plan administrator may determine that an order is not qualified only on the basis of the requirements set forth in section 206(d)(3) of ERISA. In our view, nothing in section 206(d)(3) suggests that a State court (or other appropriate State agency or instrumentality) may not alter or modify a

previous domestic relations order involving the same participant and alternate payee, as long as the new domestic relations order itself meets the statutory requirements. Indeed, the purpose of section 206(d)(3) is to permit the division of marital property on divorce in accordance with the directions of the State authority with jurisdiction to achieve the appropriate disposition of property upon the dissolution of a marriage. Where a State authority reasserts jurisdiction over a marital dissolution and issues an order changing a previously established property allocation, it would appear contrary to this purpose to create additional requirements, beyond what is specified in section 206(d)(3) of ERISA, that would thwart the exercise of that authority. Accordingly, provided that a domestic relations order otherwise meets the requirements of section 206(d)(3) of ERISA, a plan administrator may not fail to qualify the domestic relations order merely because the order changes a prior assignment to the same alternate payee.[1] Thus, it is the Department's view that a plan administrator may determine, consistent with the requirements of section 206(d)(3), that a domestic relations order is qualified even if it would supersede or amend a pre-existing QDRO assigning the same participant's benefits to the same alternate payee.

The plan administrator in this case has made apparent its intention to seek repayments from, or to withhold future payments to, the alternate payee of amounts paid out in accordance with the 1997 Order. We do not believe that, under these facts, the plan administrator would have the authority to do so. As a general matter, a plan administrator making QDRO determinations has fiduciary duties applicable to the determination process. The administrator has a duty under section 206(d)(3)(G) of ERISA to determine whether a domestic relations order is a QDRO within a reasonable time after receipt and to promptly notify the participant and each alternate payee of the determination. The administrator has a duty under section 404(a)(1) of ERISA to act prudently and solely in the interests of the plan's participants and beneficiaries, and to follow the plan's QDRO procedures unless they conflict with the provisions of ERISA.

Because, in this case, the plan administrator had previously determined the 1997 Order to be a QDRO, the plan was required to make benefit payments in accordance with the 1997 Order. The plan administrator took no steps to preserve the amounts that would be affected by the 2002 Order during its consideration of that order's qualified status, but continued to make the payments required by the 1997 Order. Subparagraph (I) of section 206(d)(3) of ERISA provides that, if a plan fiduciary, acting in accordance with its fiduciary duties, treats a domestic relations order as being qualified, and pays out benefits in accordance with its determination and the 18-month segregation rules of subparagraph (H), the plan's obligations to the participant and any alternate payee are discharged with respect to such payments.[2] Accordingly, under these circumstances it is appropriate to treat the 2002 Order as prospective only. There does not appear to be grounds on which the plan could seek repayment from the alternate payee of the benefits paid out in accordance with the 1997 Order.[3]

[1]Section 206(d)(3)(D)(iii), which provides that a domestic relations order may be qualified only if it does not require the payment of benefits to an alternate payee that are required to be paid to another alternate payee under a pre-existing QDRO, does not apply here, where there is only one alternate payee.

[2]Although § 206(d)(3)(H) requires an administrator to segregate amounts that would be payable to an alternate payee under an order for 18 months pending determination of the order's qualified status, that section does not require segregation of amounts that would be transferred from the alternate payee (per a previously recognized QDRO) to the participant. Nonetheless, the administrator may have been able, under these facts, to arrange a voluntary escrow of the amounts in question, since both the participant and the alternate payee apparently sought the change in assignment.

[3]Nothing in this letter is intended to alter or have any effect on the federal tax consequences under the Internal Revenue Code (the Code) to the participant and alternative payee of distributions under either the 1997 Order or the 2002 Order.

This letter constitutes an advisory opinion under ERISA Procedure 76-1, 41 Fed. Reg. 36281 (1976). Accordingly, this letter is issued subject to the provisions of that procedure, including section 10 thereof, relating to the effect of advisory opinions.

Sincerely,
Louis Campagna
Chief, Division of Fiduciary
Interpretations
Office of Regulations
and Interpretations

Field Assistance Bulletin 2003-3

May 19, 2003

Memorandum for: Virginia C. Smith
Director of Enforcement, Regional Directors

From: Robert J. Doyle
Director of Regulations and Interpretations

Subject: Allocation of Expenses in a Defined Contribution Plan

Issue

What rules apply to how expenses are allocated among plan participants in a defined contribution pension plan?

Background

A number of questions have been raised in the course of investigations and otherwise concerning the propriety of certain expense allocation practices in defined contribution plans. This memorandum is intended to respond to the various requests for guidance from the National and Regional Offices on these issues.[1]

The two principal issues raised with respect to the allocation of plan expenses in defined contribution plans involve the extent to which plan expenses are required to be allocated on a pro rata, rather than per capita, basis and the extent to which plan expenses may properly be charged to an individual participant, rather than plan participants as a whole. For purposes of discussing these issues, we assume first that the expenses at issue are proper plan expenses[2](2) and second that, with respect to the plan as a whole, the amount of the expenses at issue are reasonable with respect to the services to which they relate.

Analysis

ERISA contains no provisions specifically addressing how plan expenses may be allocated among participants and beneficiaries. The Act and implementing regulations, however, do address certain instances in which a plan may impose charges on particular participants and beneficiaries. For example, section 104(b)(4) provides that the plan administrator may impose a reasonable charge to cover the cost of furnishing copies of plan documents and instruments upon request of a participant or beneficiary.[3] Also, section 602 permits group health plans, subject to certain conditions, to require the payment of 102% of the applicable premium for any period of continuation coverage elected by

[1]The views set forth herein relate solely to the application of Title I of ERISA. We express no view as to whether any particular allocation of expenses might violate the Internal Revenue Code or any other Federal statute.
[2]See Advisory Opinion No. 2001-01A and related hypotheticals for discussion of the principles applicable to distinguishing settlor from plan expenses.
[3]See § 29 CFR 2520.104b-30. See also § 2520.104-4(b)(2)(ii).

an eligible participant or beneficiary. Further, the Department's regulations under sections 404(c) and 408(b)(1) provide that reasonable expenses associated with a participant's exercise of an option under the plan to direct investments or to take a participant loan may be separately charged to the account of the individual participant.[4] By contrast, regulations may limit the ability of a plan to charge a particular participant or beneficiary by requiring that information be furnished free of charge upon request of a participant or beneficiary.[5]

Section 404(a)(1) generally provides, in relevant part, that fiduciaries shall discharge their duties with respect to a plan "solely in the interest of the participants and beneficiaries," prudently (404(a)(1)(B)), and "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [Title I] . . . " (404(a)(1)(D)). Plan fiduciaries, therefore, would be required to implement allocation of expense provisions set forth in the plan, unless such provisions otherwise violate Title I.

Accordingly, plan sponsors and fiduciaries have considerable discretion in determining, as a matter of plan design or a matter of plan administration, how plan expenses will be allocated among participants and beneficiaries.

Allocating Expenses Among All Participants - Pro rata v. Per capita

In analyzing formulas for allocating expenses among all plan participants, the starting point is a review of the instruments governing the plan. Inasmuch as ERISA does not specifically address the allocation of expenses in defined contribution plans, a plan sponsor, as noted above, has considerable discretion in determining the method of expense allocation. Where the method of allocating expenses is determined by the plan sponsor (i.e., set forth in the plan documents), fiduciaries, consistent with section 404(a)(1)(D), will be required to follow the prescribed method of allocation. The fiduciary's obligation in this regard does not change merely because the allocation method favors a class (or classes) of participants. When set forth in plan documents, the method of allocating expenses, in effect, becomes part of defining the benefit entitlements under the plan.[6]

When the plan documents are silent or ambiguous on this issue, fiduciaries must select the method or methods for allocating plan expenses. A plan fiduciary must be prudent in the selection of the method of allocation. Prudence in such instances would, at a minimum, require a process by which the fiduciary weighs the competing interests of various classes of the plan's participants and the effects of various allocation methods on those interests. In addition to a deliberative process, a fiduciary's decision must satisfy the "solely in the interest of participants" standard. In this regard, a method of allocating expenses would not fail to be "solely in the interest of participants" merely because the selected method disfavors one class of participants, provided that a rational basis exists for the selected method.[7] On the other hand, if a method of allocation has no reasonable relationship to the services

[4]See § 2550.404c-1(b)(2)(ii)(A) and 54 FR 30520, 30522 (July 20, 1989)(preamble to 29 CFR § 2550.408b-1).
[5]See §§ 2520.104-46(b)(1)(i)(C), 2520.104b-1(c)(1)(iii) and (iv), 2520.104b-30.
[6]If a plan is intended to be a tax qualified plan, the fiduciary would have a duty to assure that the allocation method does not negatively affect the tax qualified status of the plan.
[7]In reviewing the propriety of such fiduciary actions, the judicial standard is whether the fiduciary acted in an arbitrary or capricious manner. In meeting this standard, the fiduciary has a duty of impartiality to all the plan's participants and may appropriately balance the interests of different classes of participants in evaluating a proposed method of expense allocation. See Varity Corp. v. Howe, 516 U.S. 489, 514 (1996); Restatement

furnished or available to an individual account, a case might be made that the fiduciary breached his fiduciary duties to act prudently and "solely in the interest of participants" in selecting the allocation method. Further, in the case where the fiduciary is also a plan participant, the selection of the method of allocation may raise issues under the prohibited transaction provisions of section 406 of ERISA where the benefit to the fiduciary is more than merely incidental.[8] For example, if in anticipation of the plan fiduciary's own divorce, the fiduciary who is also a plan participant decides to change the allocation of expenses related to a determination of whether a domestic relations order constitutes a "qualified" order from the account incurring the expense to the plan as a whole, such change in allocation by the fiduciary could constitute an act of self-dealing under section 406 of ERISA.

While a pro rata method of allocating expenses among individual accounts (i.e., allocations made on the basis of assets in the individual account) would appear in most cases to be an equitable method of allocation of expenses among participants, it is not the only permissible method. A per capita method of allocating expenses among individual accounts (i.e., expenses charged equally to each account, without regard to assets in the individual account) may also provide a reasonable method of allocating certain fixed administrative expenses of the plan, such as recordkeeping, legal, auditing, annual reporting, claims processing and similar administrative expenses. On the other hand, where fees or charges to the plan are determined on the basis of account balances, such as investment management fees, a per capita method of allocating such expenses among all participants would appear arbitrary. With regard to services which provide investment advice to individual participants, a fiduciary may be able to justify the allocation of such expenses on either a pro rata or per capita basis and without regard to actual utilization of the services by particular individual accounts. Investment advice services might also be charged on a utilization basis, as discussed below, whereby the expense will be allocated to an individual account solely on the basis of a participant's utilization of the service.

Allocating Expenses to an Individual v. General Plan Expense

In contrast to the preceding discussion, which focused on methods of allocating plan expenses among all participants, the following discussion focuses on the extent to which an expense may be allocated (or charged) solely to a particular participant's individual account, rather than allocated among the accounts of all participants (e.g., on a pro rata or per capita basis). The Department provided some guidance on this issue in Advisory Opinion No. 94-32A. In analyzing the extent to which a plan may charge a participant (or alternate payee) for a determination as to whether a domestic relations order constitutes a "qualified" order, the Department concluded in AO 94-32A that imposing the costs of a QDRO determination solely on the participant (or alternate payee) seeking the QDRO, rather than the plan as a whole, would violate ERISA.

Since the issuance of AO 94-32A, the Department has had an opportunity to review the Act and the opinion in the context of a broader array of plan expense allocation issues raised in the course of investigations. On the basis of this review, the Department has determined that neither the analyses or conclusions set forth in that opinion are legally compelled by the language of the statute. Except for the few instances in which ERISA specifically addresses the imposition of expenses on individual participants, the statute places few constraints on how expenses are allocated among plan participants.

(Second) of Trusts §183.

[8]See Advisory Opinion No. 2000-10A.

In this regard, the same principles applicable to determining the method of allocating expenses among all participants, as discussed above, apply to determining the permissibility of allocating specific expenses to the account of an individual participant, rather than the plan as a whole (i.e., among all participants).[9]

Examples of Specific Plan Expenses

Hardship Withdrawals. Some plans may provide for the allocation of administrative expenses attendant to hardship withdrawal distributions to the participant who seeks the withdrawal. ERISA does not specifically preclude the allocation of reasonable expenses attendant to hardship withdrawals to the account of the participant or beneficiary seeking the withdrawal.

Calculation of Benefits Payable under Different Plan Distribution Options. Some defined contribution plans may charge participants for a calculation of the benefits payable under the different distribution options available under the plan (e.g., joint and survivor annuity, lump sum, single life annuity, etc.). ERISA does not specifically preclude the allocation of reasonable expenses attendant to the calculation of benefits payable under different distribution options available under the plan to the account of the participant or beneficiary seeking the information.

Benefit Distributions. Some plans provide for the imposition of benefit distribution charges on the participant to whom the distribution is being made. These charges may be assessed for benefit distributions paid on a periodic basis (e.g., monthly check writing expenses). ERISA does not specifically preclude the allocation of reasonable expenses attendant to the distribution of benefits to the account of the participant or beneficiary seeking the distribution.

Accounts of Separated Vested Participants. Some plans, with respect to which the plan sponsor generally pays the administrative expenses of the plan, provide for the assessment of administrative expenses against participants who have separated from employment. In general, it is permissible to charge the reasonable expenses of administering a plan to the individual accounts of the plan's participants and beneficiaries. Nothing in Title I of ERISA limits the ability of a plan sponsor to pay only certain plan expenses or only expenses on behalf of certain plan participants. In the latter case, such payments by a plan sponsor on behalf of certain plan participants are equivalent to the plan sponsor providing an increased benefit to those employees on whose behalf the expenses are paid. Therefore, plans may charge vested separated participant accounts the account's share (e.g., pro rata or per capita) of reasonable plan expenses, without regard to whether the accounts of active participants are charged such expenses and without regard to whether the vested separated participant was afforded the option of withdrawing the funds from his or her account or the option to roll the funds over to another plan or individual retirement account.

Qualified Domestic Relations Orders (QDROs) and Qualified Medical Child Support Order (QMCSOs) Determinations. ERISA does not, in our view, preclude the allocation of reasonable expenses attendant to QDRO or QMCSO determinations to the account of the participant or beneficiary

[9]The views expressed herein supersede the views expressed in AO 94-32A.

seeking the determination.[10]

It should be noted that, pursuant to 29 CFR § 2520.102-3(l), plans are required to include in the Summary Plan Description a summary of any provisions that may result in the imposition of a fee or charge on a participant or beneficiary, or the individual account thereof, the payment of which is a condition to the receipt of benefits under the plan. In addition, § 2520.102-3(l) provides that Summary Plan Descriptions must include a statement identifying the circumstances that may result in the " . . . offset, [or] reduction . . . of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits . . ." These requirements are intended to ensure that participants and beneficiaries are apprised of fees and charges that may affect their benefit entitlements.

Questions concerning the information contained in this Bulletin may be directed to the Division of Fiduciary Interpretations, Office of Regulations and Interpretations, (202)693-8510.

[10]See footnote 9.

Appendix B

ERISA
Advisory Opinion Procedure

The following first appeared in the Federal Register, Volume 41, No. 168, pg. 36281. August 27, 1976

ERISA Procedure 76-1 For ERISA Advisory Opinions

It is the practice of the Department of Labor to answer inquiries of individuals or organizations affected, directly or indirectly, by the Employee Retirement Income Security Act of 1974 (Pub. L. 93-406, hereinafter the Act) as to their status under the Act and as to the effect of certain acts and transactions. The answers to such inquiries are categorized as information letters and advisory opinions. This ERISA procedure describes the general procedures of the Department in issuing information letters and advisory opinions under the Act, and is designed to promote efficient handling of inquiries and to facilitate prompt responses.

Section 7 of this procedure is reserved and will set forth the procedures to be followed to obtain an advisory opinion relating to prohibited transactions and common definitions, such as whether a person is a party in interest and a disqualified person. In general, this section will incorporate a revenue procedure to be published by the Internal Revenue Service.

SEC 1. *Purpose*. The purpose of this ERISA Procedure is to describe the general procedures of the Department of Labor in issuing information letters and advisory opinions to individuals and organizations under the Employee Retirement Income Security Act of 1974 (Pub. L. 93-406), hereinafter referred to as the Act. This ERISA Procedure also informs individuals and organizations, and their authorized representatives, where they may direct requests for information letters and advisory opinions, and outlines procedures to be followed in order to promote efficient handling of their inquiries.

SEC 2. *General Practice*. It is the practice of the Department to answer inquiries of individuals and organizations, whenever appropriate, and in the interest of sound administration of the Act, as to their status under the Act and as to the effects of their acts or transactions. One of the functions of the Department is to issue information letters and advisory opinions in such matters.

SEC 3. *Definitions*. .01 An information letter is a written statement issued either by the Pension and Welfare Benefit Programs (Office of Employee Benefits Security), U.S. Department of Labor, Washington, D.C. or a Regional Office or an Area Office of the Labor-Management Services Administration, U.S. Department of Labor, that does no more than call attention to a well-established interpretation or principle of the Act, without applying it to a specific factual situation. An information letter may be issued to any individual or organization when the nature of the request from the individual or the organization suggests

that it is seeking general information, or where the request does not meet all the requirements of section 6 or section 7 of this procedure, and it is believed that such general information will assist the individual or organization.

.02 An advisory opinion is a written statement issued to an individual or organization, or to the authorized representative of such individual or organization, by the Administrator of Pension and Welfare Benefit Programs or his delegate, that interprets and applies the Act to a specific factual situation. Advisory opinions are issued only by the Administrator of Pension and Welfare Benefit Programs or his delegate.

.03 Individuals and organizations are those persons described in section 4 of this procedure.

SEC 4. *Individuals and Organizations Who May Request Advisory Opinions or Information Letters*. .01 Any individual or organization affected directly or indirectly, by the Act may request an information letter or an advisory opinion from the Department.

.02 A request by or for an individual or organization must be signed by the individual or organization, or by the authorized representative of such individual or organization. See section 7.03 of this procedure.

SEC 5. *Discretionary Authority to Render Advisory Opinions*. .01 The Department will issue advisory opinions involving the interpretation of the application of one or more sections of the Act, regulations promulgated under the Act, interpretive bulletins, or exemptions issued by the Department to a specific factual situation. Generally, advisory opinions will be issued by the Department only with respect to prospective transactions (i.e., a transaction which will be entered into). Moreover, there are certain areas where, because of the inherently factual nature of the problem involved, or because the subject of the request for opinion is under investigation for a violation of the Act, the Department ordinarily will not issue advisory opinions. Generally, an advisory opinion will not be issued on alternative courses of proposed transactions, or on hypothetical situations, or where all parties involved are not sufficiently identified and described, or where material facts or details of the transaction are omitted.

.02 The Department ordinarily will not issue advisory opinions relating to the following sections of the Act:

.02(a) Section 3(18), relating to whether certain consideration constitutes adequate consideration;

.02(b) Section 3(26), relating to whether the valuation of any asset is at current value;

.02(c) Section 3(27), relating to whether the valuation of any asset is at present value;

.02(d) Section 102(a)(1), relating to whether a summary plan description is written in a manner calculated to be understood by the average participant;

.02(e) Section 103(a)(3)(A), relating to whether the financial statements and schedules required to be included in the Annual Report are presented fairly in conformity with generally accepted accounting principles applied on a consistent basis;

.02(f) Section 103(b)(1), relating to whether a matter must be included in a financial statement in order to fully and fairly present the financial statement of the plan;

.02(g) Section 202 (other than section 202(a)(3) and (b)(1)) relating to minimum participation standards;

.02(h) Section 203 (other than sections 202(a)(3)(B), (b)(1) (flush language), (b)(2), (b)(3)(A);

.02(i) Section 204 of the Act (other than sections 204(b)(1)(B), (b)(1)(A), (C), (D), (E)), relating to benefit accrual requirements;

.02(j) Section 205(e), relating to the period during which a participant may elect in writing not to receive a joint and survivor annuity;

.02(k) Section 208, relating to mergers and consolidation of plans or transfer of plan assets;

.02(l) Section 209(a)(1), relating to whether the report required by section 209(a)(1) is sufficient to inform the employee of his accrued benefits under the plan, etc.;

.02(m) Sections 302 through 305, relating to minimum funding standards;

.02(n) Section 403(c)(1), relating to the purposes for which plan assets must be held;

.02(o) Section 404(a), relating to fiduciary duties as applied to particular conduct; and,

.02(p) Section 407(a)(2) and (3) and (c)(1), relating to fair market value, as applied to whether the value of any particular security or real property constitutes fair market value.

This list is not all inclusive and the Department may decline to issue advisory opinions relating to other sections of the Act whenever warranted by the facts and circumstances of a particular case. The Department may, when it is deemed appropriate and in the best interest of sound administration of the Act, issue information letters calling attention to established principles under the Act, even though the request that was submitted was for an advisory opinion.

.03 Pending the adoption of regulations (either temporary or final) involving the interpretation of the application of a provision of the Act, consideration will be given to the issuance of advisory opinions relating to such provisions of the Act only under the following conditions:

.03(a) If an inquiry presents an issue on which the answer seems to be clear from the application of the provisions of the Act to the facts described, the advisory opinion will be issued in accordance with the procedures contained herein.

.03(b) If an inquiry presents an issue on which the answer seems reasonably certain but not entirely free from doubt, an advisory opinion will be issued only if it is established to the satisfaction of the Department, that a business emergency requires an advisory opinion or that unusual hardship to the plan or its participants and beneficiaries will result from failure to obtain an advisory opinion. In any case in which the individual or organization believes that a business emergency exists or that an unusual hardship to the plan or its participants and beneficiaries will result from the failure to obtain an advisory opinion, the individual or organization should submit with the request a separate letter setting forth the facts necessary for the Department to make a determination in this regard. In this connection, the Department will not deem a business emergency to result from circumstances within the control of the individual or organization such as, for example, scheduling within an inordinately short time the closing date of a transaction or a meeting of the Board of Directors or the shareholders of a corporation.

.03(c) If an inquiry presents an issue that cannot be reasonably resolved prior to the issuance of a regulation, an advisory opinion will not be issued.

.04 The Department ordinarily will not issue advisory opinions on the form or effect in operation of a plan, fund, or program (or a particular provision or provisions thereof) subject to Title I of the Act. For example, the Department will not issue an advisory opinion on whether a plan satisfies the requirements of Parts 2 and 3 of Title I of the Act.

SEC 6. *Instructions To Individuals and Organizations Requesting Advisory Opinions From the Department*. .01 If an advisory opinion is desired, a request should be submitted to:

U.S. Department of Labor
Employee Benefits Security Administration
Office of Regulations and Interpretations
200 Constitution Avenue, NW, Suite N-5655
Washington, DC 20210

.02 A request for an advisory opinion must contain the following information:

.02(a) The name and type of plan or plans (e.g., pension, profit-sharing, or welfare plan); the Employer Identification Number (EIN); the Plan Number (PN) used by the plan in reporting to the Department of Labor on Form EBS-1 or a copy of the first two pages of the most recent Form EBS-1 filed with the Department.

.02(b) A detailed description of the act or acts or transaction or transactions with respect to which an advisory opinion is requested. Where the request pertains to only one step of a larger integrated act or transaction, the facts, circumstances, etc., must be submitted with respect to the entire transaction. In addition, a copy of all documents submitted must be included in the individual's or organization's statement and not merely incorporated by reference, and must be accompanied by an analysis of their bearing on the issue or issues, specifying the pertinent provisions.

.02(c) A discussion of the issue or issues presented by the act or acts or transaction or transactions which should be addressed in the advisory opinion.

.02(d) If the individual or organization is requesting a particular advisory opinion, the requesting party must furnish an explanation of the grounds for the request, together with a statement of relevant supporting authority. Even though the individual or organization is urging no particular determination with regard to a proposed or prospective act or acts or transaction or transactions, the party requesting the ruling must state such party's views as to the results of the proposed act or acts or transaction or transactions and furnish a statement of relevant authority to support such views.

.03 A request for an advisory opinion by or for an individual or organization must be signed by the individual or organization or by the individual's or organization's authorized representative. If the request is signed by a representative of an individual or organization, or the representative may appear before the Department in connection

with the request, the request must include a statement that the representative is authorized to represent the individual or organization.

.04 A request for an advisory opinion that does not comply with all the provisions of this procedure will be acknowledged, and the requirements that have not been met will be noted. Alternatively, at the discretion of the Department, the Department will issue an information letter to the individual or organization.

.05 If the individual or organization or the authorized representative, desires a conference in the event the Department contemplates issuing an adverse advisory opinion, such desire should be stated in writing when filing the request or soon thereafter in order that the Department may evaluate whether in the sole discretion of the Department, a conference should be arranged and at what stage of the consideration a conference would be most helpful.

.06 It is the practice of the Department to process requests for information letters and advisory opinions in regular order and as expeditiously as possible. Compliance with a request for consideration of a particular matter ahead of its regular order, or by a specified time, tends to delay the disposition of other matters. Requests for processing ahead of the regular order, made in writing (submitted with the request or subsequent thereto) and showing clear need for such treatment, will be given consideration as the particular circumstances warrant. However, no assurance can be given that any letter will be processed by the time requested. The Department will not consider a need for expedited handling to arise if the request shows such need has resulted from circumstances within the control of the person making the request.

.07 An individual or organization, or the authorized representative desiring to obtain information relating to the status of his or her request for an advisory opinion may do so by contacting the Office of Regulatory Standards and Exceptions, Pension and Welfare Benefit Programs, U.S. Department of Labor, Washington, D.C.

SEC. 7. *Instructions to Individuals and Organizations Requesting Advisory Opinions Relating to Prohibited Transactions and Common Definitions*. .01 [Reserved]

.02 [Reserved]

.03 [Reserved]

SEC. 8. *Conferences at Department of Labor*. If a conference has been requested and the Department determines that a conference is necessary or appropriate, the individual or

organization or the authorized representative will be notified of the time and place of the conference. A conference will normally be scheduled only when the Department in its sole discretion deems it will be necessary or appropriate in deciding the case. If conferences are being arranged with respect to more than one request for an opinion letter involving the same individual or organization, they will be so scheduled as to cause the least inconvenience to the individual or organization.

SEC. 9. *Withdrawal of Requests.* The individual or organization's request for an advisory opinion may be withdrawn at any time prior to receipt of notice that the Department intends to issue an adverse opinion, or the issuance of an opinion. Even though a request is withdrawn, all correspondence and exhibits will be retained by the Department and will not be returned to the individual or organization.

SEC. 10. *Effect of Advisory Opinion*. An advisory opinion is an opinion of the Department as to the application of one or more sections of the Act, regulations promulgated under the Act, interpretive bulletins, or exemptions. The opinion assumes that all material facts and representations set forth in the request are accurate, and applies only to the situation described therein. Only the parties described in the request for opinion may rely on the opinion, and they may rely on the opinion only to the extent that the request fully and accurately contains all the material facts and representations necessary to issuance of the opinion and the situation conforms to the situation described in the request for opinion.

SEC. 11. *Effect of Information Letters*. An information letter issued by the Department is informational only and is not binding on the Department with respect to any particular factual situation.

SEC. 12. *Public Inspection*. .01 Advisory opinions shall be open to public inspection at the Public Disclosure Room, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20216.

.02 Background files (including the request for an advisory opinion, correspondence between the Department and the individual or organization requesting the advisory opinion) shall be available upon written request. Background files may be destroyed after three years from the date of issuance.

.03 Advisory opinions will be modified to delete references to proprietary information prior to disclosure. Any information considered to be proprietary should be so specified in a separate letter at the time of request. Other than proprietary information, all materials contained in the public files shall be available for inspection pursuant to section 12.02.

.04 The cost of search, copying and deletion of any references to proprietary information will be borne by the person requesting the advisory opinion or the background file.

SEC. 13. *Effective Date*. This advisory opinion procedure consists of rules of agency procedure and practice, and is therefore excepted under 5 U.S.C. 552(b)(3)(A) of the Administrative Procedure Act from the ordinary notice and comment provisions for agency rulemaking. Accordingly, the procedure is effective August 27, 1976, the date of its publication in the Federal Register.

Signed at Washington, DC, this 24th day of August 1976

James D. Hutchinson
Administrator of Pension and Welfare Benefit Programs
U.S. Department of Labor

[FR Doc. 76-25168 Filed 8-26-76;8:45 am]

Appendix C

IRS Sample Language for a Qualified Domestic Relations Order

Appendix C - IRS Sample Language for a QDRO

The following document, which contains sample language for inclusion in a form for a QDRO and discussion of the sample language, was issued by the Department of the Treasury and the Internal Revenue Service in compliance with Congressional directives contained in the Small Business Job Protection Act of 1986, section 1457(a)(2). It appeared in Internal Revenue Bulletin 1997-2 at p. 49 (Jan. 13, 1997). This document was developed in consultation with the Department of Labor and is reprinted here for the convenience of the reader.

Part III - Administrative, Procedural and Miscellaneous Sample Language for a Qualified Domestic Relations Order Notice 97-11

Purpose

This Notice provides information intended to assist domestic relations attorneys, plan participants, spouses and former spouses of participants, and plan administrators in drafting and reviewing a qualified domestic relations order ("QDRO"). The Notice provides sample language that may be included in a QDRO relating to a plan that is qualified under § 401(a) or § 403(a) of the Internal Revenue Code of 1986 ("qualified plan" or "plan") and that is subject to § 401(a)(13). The Notice also discusses a number of issues that should be considered in drafting a QDRO. A QDRO is a domestic relations order that provides for payment of benefits from a qualified plan to a spouse, former spouse, child or other dependent of a plan participant and that meets certain requirements.

Statutory QDRO Requirements

Section 401(a)(13)(A) of the Code provides that benefits under a qualified plan may not be assigned or alienated. Section 401(a)(13)(B) establishes an exception to the antialienation rule for assignments made pursuant to domestic relations orders that constitute QDROs within the meaning of § 414(p). A "domestic relations order" is defined in § 414(p)(1)(B) as any judgment, decree, or order (including approval of a property settlement agreement) that: (i) relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant (ii) is made pursuant to a State domestic relations law (including a community property law). There is no exception to the § 401(a)(13)(A) antialienation rule for assignments made pursuant to domestic relations orders that are not QDROs.

Section 414(p)(1)(A) provides, in general, that a QDRO is a domestic relations order that creates or recognizes the existence of an alternate payee's right, or assigns to an alternate payee the right, to receive all or a portion of the benefits payable with respect to a participant under a plan, and that meets the requirements of paragraphs (2) and (3) of § 414(p). Section 414(p)(2) requires that a QDRO clearly specify: (A) the name and last known mailing address (if any) of the participant and of each alternate payee covered by the order, (B) the amount or percentage of the participant's benefits to be paid by the plan to each alternate payee, or the manner in which that amount or percentage is to be determined, (C) the number of payments or period to which the order applies.

Section 414(p)(3) provides that a QDRO cannot require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan; cannot require a plan to provide increased benefits (determined on the basis of actuarial value); and cannot require the payment of benefits to an alternate payee that are required to be paid to another alternate payee under another order previously determined to be a QDRO. Section 414(p)(4)(A)(i) provides that a domestic relations order shall not be treated as failing to meet the requirements of § 414(p)(3)(A) (and thus will not fail to be a QDRO) solely because the order requires payment of benefits to an alternate payee on or after the participant's earliest retirement age, even if the participant has not separated from service at that time. Section 414(p)(4)(B) defines earliest retirement age as the earlier of (i) the date on which the participant is entitled to a distribution under the plan, or (ii) the later of (I) the date the participant attains age 50, or (II) the earliest date on which the participant could begin receiving benefits under the plan if the participant separated from service.

Section 414(p)(5) permits a QDRO to provide that the participant's former spouse shall be treated as the participant's surviving spouse for purposes of §§ 401(a)(11) and 417 (relating to the right to receive survivor benefits and requirements concerning consent to distributions), and that any other spouse of the participant shall not be treated as a spouse of the participant for these purposes. An alternate payee is defined under § 414(p)(8) as any spouse, former spouse, child or other dependent of a participant who is recognized by a domestic relations order as having a right to receive all, or a portion of, the benefits payable under a plan with respect to the participant. Section 414(p)(10) provides that a plan shall not fail to satisfy the requirements of § 401(a), 401(k) or 403(b) solely by reason of payments made to an alternate payee pursuant to a QDRO.

B. Small Business Job Protection Act of 1996

Section 1457(a)(2) of the Small Business Job Protection Act of 1996 ("SBJPA") directs the Secretary of the Treasury ("Secretary") to develop sample language for inclusion in a form for a QDRO described in § 414(p)(1)(A) of the Code and §206(d)(3)(B)(i) of the Employee Retirement Income Security Act of 1974 ("ERISA") that meets the requirements contained in those sections, and the provisions of which focus attention on the need to consider the treatment of any lump sum payment, qualified joint and survivor annuity ("QJSA"), or qualified preretirement survivor annuity ("QPSA"). Accordingly, the Service and Treasury are publishing the discussion and sample QDRO language set forth in the Appendix to this Notice.

Section 1457(a)(1) of the SBJPA directs the Secretary to publish sample language that can be included in a form that is used for a spouse to consent to a participant's waiver of a QJSA or QPSA. This sample language for use in spousal consent forms is contained in Notice 97-10 in this Bulletin.

C. Department of Labor Interpretive Authority

Section 206(d)(3) of ERISA (29 U.S.C. § 1056(d)(3)) contains QDRO provisions that are substantially parallel to those of § 414(p) of the Code. The Department of Labor has jurisdiction to interpret these provisions (except to the extent provided in § 401(n) of the Code) and the provisions governing the fiduciary duties owed with respect to domestic relations orders and QDROs. Section 401(n) gives the Secretary of the Treasury the authority to prescribe rules or regulations necessary to coordinate the requirements of §§ 401(a)(13) and 414(p), and the regulations issued by the Department of Labor thereunder, with other Code provisions. The Department of Labor has reviewed this Notice, including its Appendix, and has advised the Service and Treasury that the discussion and sample language are consistent with the views of the Department of Labor concerning the statutory requirements for QDROs. This Notice, including its Appendix, is not intended by the Service or Treasury to convey interpretations of the statutory requirements applicable to QDROs, but only to provide examples of language that may be (but are not required to be) used in drafting a QDRO that satisfies these requirements.

II. SAMPLE LANGUAGE

The appendix to this notice has two parts. Part I discusses certain issues that should be considered when drafting a QDRO. Part II contains sample language that will assist in drafting a QDRO. Drafters who use the sample language will need to conform it to the terms of the retirement plan to which the QDRO applies, and to specify the amounts assigned and other terms of the QDRO so as to achieve an appropriate division of marital property or level of family support. A domestic relations order is not required to incorporate the sample language in order to satisfy the requirements for a QDRO, and a domestic relations order that incorporates part of the sample language may omit or modify other parts.

The sample language addresses a variety of matters, but is not designed to address all retirement benefit issues that may arise in each domestic relations matter or QDRO. Further, some of the sample language, while helpful in facilitating the administration of a QDRO, is not necessarily required for the order to satisfy the requirements for a QDRO. Alternative formulations would be permissible for use in drafting orders that meet the statutory requirements for a QDRO.

III. OTHER SOURCES OF INFORMATION

The Pension Benefit Guaranty Corporation ("PBGC") recently published a booklet entitled Divorce Orders & PBGC, which discusses the special QDRO rules that apply for plans that have been terminated and are trusteed by PBGC, and provides model QDROs for use with those plans.

This publication may be obtained by calling PBGC's Customer Service Center at 1-800-400-PBGC or via the PBGC Web site at http://www.pbgc.gov

Additional information on the rights of participants and spouses to plan benefits can be found in a two-booklet set published by the Service, entitled Looking Out for #2. These booklets discuss retirement benefit choices under a defined contribution or a defined benefit plan, and may be obtained by calling the Internal Revenue Service at 1-800-TAX-FORM, and asking for Publication 1565 (defined contribution plans) or Publication 1566 (defined benefit plans).

IV COMMENTS

The Service invites the public to comment on the QDRO discussion and sample language included in the Appendix to this Notice, and welcomes suggestions concerning possible additional sample language. Comments may be submitted to the Internal Revenue Service at CC:DOM:CORP:R (Notice 97-11), Room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, D.C. 20044. Alternatively, taxpayers may hand-deliver comments between the hours of 8 a.m. and 5 p.m. to CC:DOM:CORP:R (Notice 97-11), Courier's desk, Internal Revenue Service, 1111 Constitution Ave., N.W., Washington, D.C., or may submit comments electronically via the IRS Web Site at http://www.irs.ustreas.gov/prod/tax_regs/comments.html

DRAFTING INFORMATION

The principal authors of this Notice are Diane S. Bloom of the Employee Plans Division and Susan M. Lennon of the Office of the Associate Chief Counsel (Employee Benefits and Exempt Organizations); however, other personnel from the Service and Treasury contributed to its development. For further information regarding this Notice, please contact the Employee Plans Division's taxpayer assistance telephone service at 202.622.6074/6075, between the hours of 1:30 p.m. and 4 p.m. Eastern Time, Monday through Thursday. Alternatively, please call Ms. Bloom at (202) 622-6214 or Ms. Lennon at (202) 622-4606. Questions concerning QDROs may be addressed ~~to Susan G. Lahne of the Pension and Welfare Benefits Administration, Department of Labor, at 202.219.7461.~~* These telephone numbers are not toll-free.

*The Office of Regulations and Interpretations, Employee Benefits Security Administration, Department of Labor, at (202) 693-8500.

Appendix

Part I of this Apendix discusses certain issues that are relevant in drafting a qualified domestic relations order ("QDRO"). Part II of this Appendix contains sample language that can be used in a QDRO. However, the discussion and sample language do not attempt to address every issue that may arise in drafting a QDRO. Alos, some parts of the discussion are not relevant to all situations and some parts of the sample language are not appropriate for all QDROs. In formulating a particular QDRO, it is important that the drafters tailor the QDRO to the needs of the parties and ensure that the QDRO is consistent with the terms of the retirement plan to which the QDRO applies.

PART I. DISCUSSION OF QDRO REQUIREMENTS AND RELATED ISSUES

In order to be recognized as a QDRO, an order must first be a "domestic relations order." A domestic relations order is any judgment, decree or order (including approval of a property settlement) which (i) relates to the provision of child support, alimony payments or marital property rights to a spouse, former spouse, child or other dependent of the plan participant, and (ii) is made pursuant to a State domestic relations law (including a community property law). A State authority must actually issue an order or formally approve a propsed property settlement before it can be a domestic relations order. A property settlement signed by a participant and the participant's former spuse or a draft order to which both parties consent is not a domestic relations order untl the State authority has adopted it as an order or formally approved it and made it part of the domestic relations proceeding.

The sample language in Part II assumes that the QDRO applies to one qualified plan and one alternate payee. If a QDRO is intended to cover more than one qualified plan or alternate payee, the QDRO should clearly state which qualified plan and which alternate payee each provision is intended to address.

The terms of a qualified plan must be set forth in a written document. The plan must also establish written QDRO procedures to be used by the plan aministrator in determining whether a domestic relations order is a QDRO and in administering QDROs. The plan administrator maintains copies of the plan document and the plan's QDRO procedures. If the plan is required under Federal law to have a summary plan description, or "SPD," the plan administrator will also have a copy of the SPD. The information in these documents is helpful in drafting a QDRO. The drafter to of a QDRO may wish to obtain copies of these doucments before drafting a QDRO.

A. IDENTIFICATION OF PARTICIPATING AND ALTERNATE PAYEE

A QDRO must clearly specify the name and last known mailing address (if any) of the participant and of each alternate payee covered by the QDRO. In the event that an alternate payee is a minor or legally incompetent, the QDRO should also include the name and address of the alternate payee's legal representative. A QDRO can have more than one alternate payee, such as a former spouse and a child.

The "participant" is the individual whose benefits under the plan are being divided by the QDRO. Thee participant's spouse (or former spouse, child, or other dependent) who receives some or all of the plan's benefits wwith respect to the particpant under the terms of the QDRO is the "alternate payee."

B. IDENTIFICATION OF RETIREMENT PLAN

A QDRO must clearly identify each plan tot which the QDRO applies. A QDRO can satisfy this requirement by stating the full name of the plan as provided in the plan document.

C. AMOUNT OF BENEFITS TO BE PAID TO ALTERNATE PAYEE

A QDRO must clearly specify the amount or percentatge of the particpant's benefits in the plan that is assigned to each alternate payee, or the manner in which the amount or percentage is to be determined. Many factors should be taken into account in determinig which benefits to assign to an alternate payee and how these benefits are to be assigned. The following discussion highlights some of these factors. Because of the complexity and variety of the factors that should be considered, and the need to tailor the assignments of benefits under a QDRO to the individual circumstances of the parties, specific sample language regarding the assingment of benefits has not been provided in Part II of this Appendix.

1. Types of Benefits

In order to decide how to divide benefits under a QDRO, the drafter first should determine the types of benefits the plan provides. Most benefits provided by qualified plans can be classified as (1) retirement benefits that are paid during the participant's life and (2) survivor benefits that are paid to beneficiaries after the particpant's death. Generally, a QDRO can assign all or a portion of each of these types of benefits to an alternate payee. The drafters of a QDRO should coordinate the assignment of these types of benefits. QDRO drafters should also consider how the benefits divided under the QDRO may be affected, under the plan, by the death of either the participant or the alternate payee.

2. Types of Qualified Plans

Another important factor to consider in the drating of a QDRO is the type of plan to which the QDRO will apply. As discussed below, the type of plan may affect the types of benefits available for assignment, how the parties choose to assign the benefits, and other matters.

There are two basic types of qualified plans to which QDROs apply: defined benefit plans and defined contribution plans.

a. Defined Benefit Plans

A "defined benefit plan" promises to pay each participant a specific benefit at retirement. The basic retirement benefits are usually based on a formula that takes into account factors such as the number of years a particpant has worked for the employer and the participant's salary. The basic retirement benefits are generally expressed in the form of periodic payments for the participant's life beginning at the plan's normal retirement age. This stream of periodic payments is generally known as an "annuity." There are special rules that apply if the participant is married; these rules are discussed in greater detail in section E below. A plan may also provide that these retirement benefits may be paid in other forms, such as a lump sum payment.

b. Defined Contribution Plans

A "defined contribution plan" is a retirement plan that provides for an individual account for each participant. The participant's benefits are based solely on the amount contributed to the participant's account, and any income, expenses, gains and losses, and any forfeitures of accounts of other particpants which may be allocated to such participant's account. Examples of defined contribution plans include a profit sharing plan (including a "401(k)" plan), an employee stock ownership plan (an "ESOP") and a money purchase pension plan. Defined contribution plans commonly permit retirement benefits to be paid in the form of a lump sum payment of the participant's entire account balance.

3. Approaches to Dividing Retirement Benefits

There are two common approaches to dividing retirement benefits in a QDRO: one awards a separate interest in the retirement benefits to the alternate payee, and the other allows the alternate payee to share in the payent of the retirement benefits. In drafting a QDRO using either of these approaches, consideration should be given to factors such as whether the plan is a defined benefit plan or defined contribution plan, and the purpose of the QDRO (such as whether the QDRO is meant to provide spousal support or child support, or to divide marital property.)

a. Separate Interest Approach

A QDRO that creates a "separate interest" divides the participant's benefits into two separate parts: one for the participant and one for the alternate payee. Subject to the terms of the plan and as discussed in more detail below, a QDRO may provide that the alternate payee can determine the form in which his or her benefits are paid and when benefit payments commence. If benefits are allocated under the separate interest approach, the drafters of a QDRO should take into account certain issues depending on the type of plan.

(1) Issues Relevant to Defined Benefit Plans

The treatment of subsidies provided by a plan and the treatment of future increases in benefits due to increases in the participant's compensation, additional years of service, or changes in the plan's provisions are among the matters that should be considered when drafting a QDRO that uses the separate interest approach to allocate benefits under a defined benefit plan.

Subsidies. Defined benefit plans may promise to pay benefits at various times and in alternative forms. Benefits paid at certain times or in certain forms may have a greater actuarial value than the basic retirement benefits payable at normal retirement age. When one form of benefit has a greater actuarial value than another form, the difference in value is often called a subsidy. Plans usually provide that a participant must meet specific eligibility requirements, such as working for a minimum number of years for the employer that maintains the plan, in order to receive the subsidy.

For example, a defined benefit plan may offer an "early retirement subsidy" to employees who retire before the plan's normal retirement age but after having worked for a specific number of years for the employer maintaining the plan. In some cases, this subsidized benefit provides payments in the form of an annuity that pays the same annual amount as would be paid if the payments commenced instead at the normal retirement age. The subsidy may be available only for certain forms of benefit.

A QDRO may award to the alternate payee all or part of the participant's basic retirement benefits. A QDRO can also address the disposition of any subsidy to which the participant may become entitled after the QDRO has been entered.

Future Increases in the Participant's Benefits. A participant's basic retirement benefits may increase due to circumstances that occur after a QDRO has been entered, such as increases in salary, crediting of additional years of service, or amendments to the plan's provisions, including amendments to provide cost of living adjustments. The treatment of such benefit increases should be considered when drafting a QDRO using the separate interest approach.

(2) Issues Relevant to Defined Contribution Plans

Investment of the amount assigned to the alternate payee when the account is invested in more than one investment vehicle and division of any future allocation of contributions or forfeitures to the participant's account are among the matters that should be considered when drafting a QDRO that allocates the alternate payee a separate interest under a defined contribution plan.

Investment Choices. The participant's account may be invested in more than one investment fund. If the plan provides for participant-directed investment

of the participant's account, consideration should be given to how the alternate payee's interest will be invested.

Future Allocations. A participant's account balance may later increase due to the allocation of contriutions or forfeitures after the QDRO has been entered. A QDRO may provide that the amounts asssigned to the alternate payee will include a portion of such future allocations.

b. Shared Payment Approach

A QDRO may use the "shared payment" approach, under which benefit payments from the plan are split between the participant and the alternate payee. The alternate payee receives payments under this approach only when the participant receives payments. A QDRO may provide that the alternate payee will commence receiving benefit payments when the participant begins receiving payments or at a later stated date, and that the alternate payee will cease to share in the benefit payments at a stated date (or upon a stated event, provided that adequate notice is given to the plan). In splitting the benefit payments, the QDRO may award the alternate payee either a percentage or a dollar amount of each of the participant's benefit payments; in either case, the amount awarded cannot exceed the amount of each payment to which the participant is entitled under the plan. If a QDRO awards a percentage of the participant's benefit payments (rather than a dollar amount), then, unless the QDRO provides otherwise, thee alternate payee generally will automatically receive a share of any future subsidy or other increase in the participant's benefits.

D. FORM AND COMMENCEMENT OF PAYMENT TO ALTERNATE PAYEE

QDRO drafters should take into account certain issues that may arise in connection with the alternate payee's choice of a form of benefit payments and the date on which payment will commence.

1. Separate Interest Approach

a. Form of Alternate Payee's Benefit Payments

A QDRO either may specify a particular form in which payments are to be made to the alternate payee or may provide that the alternate payee may choose a form of benefit from among the options available to the participant. However, Federal law provides that the alternate payee cannot receive payments in the form of a joint and survivor annuity with respect to the alternate payee and his or her subsequent spouse.

The choice of the form of benefits should take into account the period over which payments will be made. For example, if the alternate payee elects to

receive a lump sum payment, no further payments will be made by the plan with respect to the alternate payee's interest.

Any decision concerning the form of benefit should take into account the difference, if any, in the actuarial value of different benefit forms available under the plan. For example, as discussed above, a plan might provide an early retirement subsidy that is available only for payment in certain forms.

In addition, the forms of benefit available to the alternate payee may be limited by § 401(a)(9) of the Code, which specifies the date by which benefit payments from a qualified plan must commence and limits the period over which the beneefit payments may be made. Section 1.401(a)(9)-1, Q&A H-4, of the Proposed Income Tax Regulations addresses the application of the required minimum distribution rules of § 401(a)(9) to payments to an alternate payee. Thee proposed regulation limits the period over which benefits may be paid with respect to the alternate payee's interest. For example, the proposed regulation provides that distribution of the alternate payee's separate intereest will not satisfy § 401(a)(9)(A)(ii) of the Code if the separate interest is distributed over the joint lives of the alternate payee and a designated (other than the participant).

b. Commencement of Benefit Payments to Alternate Payee

Under the separate interest approach, the alternate payee may begin receiving benefits at a different time than the participant. A QDRO either may specify a time at which payments are to commence to the alternate payee or may provide that the alternate payee can elect a time when benefits will commence in accordance with the terms of the plan. In two circumstances, an alternate payee who is given a separate interest may begin receiving his or her separate benefit before the participant is eligible to begin receiving payments. First, Federal law provides that benefit payments to the alternate payee may begin as soon as the participant attains his or her earliest retirement age. Federal law defines "earliest retirement age" as the earlier of (i) the date on which the participant is entitled to a distribution under the plan, or (ii) the later of (I) the date the participant attains age 50, or (II) the earliest date on which the participant could begin receiving benefits under the plan if the participant separated from service. Second, the retirement plan may (but is not required to) allow payments to begin to an alternate payee at a date before the earliest retirement date.

2. Shared Payment Approach

As indicated above, under the shared payment approach, benefit payments are split between the participant and the alternate payee. The alternate payee receives payments in the same form as the participant. Further, payments to the alternate payee do not commence before the participant has begun to receive benefits. Payments to the alternate payee can cease at any time stated in the QDRO but do not continue after payments with respect to

the eparticipant cease. As noted above, a QDRO must state the number of payments or the period to which the order applies.

E. SURVIVOR BENEFITS AND TREATMENT OF FORMER SPOUSE AS PARTICIPANT'S SPOUSE

Survivor benefits include both benefits payable to surviving spouses and other benefits that are payable after the participant's death. These benefits can be awarded to an alternate payee. In determining the assignment of survivor benefits, QDRO drafters should take into account that benefits awarded to the alternate payee under a QDRO will not be available to a subsequent spouse of the participant or to another beneficiary. QDRO drafters may consult with the plan administrator for information on the survivor benefits provided under the plan.

A QDRO may provide for treatment of a former spouse of a participant as the participant's spouse with respect to all or a portion of the spousal survivor benefits that must be provided under Federal law. The following discussion explains the spousal survivor benefits that must be offered under a plan, and identifies issues that should be considered in determining whether to treat the alternate payee as the participant's spouse.

Only a spouse or former spouse of the participant can be treated as a spouse under a QDRO. A child or other dependent who is an alternate payee under a QDRO cannot be treated as the spouse of a participant.

Retirement plans generally need not provide the special survivor benefits to the participant's surviving spouse unless the participant is married for at least one year. If the retirement plan to which the QDRO relates contains such a one-year marriage requirement, then the QDRO cannot require that the alternate payee be treated as the participant's spouse if the marriage lasted for less than one year.

1. Qualified Joint and Survivor Annuity

Federal law generally requires that defined benefit plans and certain defined contribution plans pay retirement benefits to participants who were married on the participant's annuity starting date (this is the first day of the first period for which an amount is payable to the participant) in a special form called a qualifed joint and survivor annuity, or QJSA. Under a QJSA, retirement payments are made monthly (or at other regular intervals) to the participant for his or her lifetirme; after the participant dies, the plan pays the participant'surviving spouse an amount each mothe (or other regular interval) that is at least one half of the retirement benefit that was paid to the participant. At any time that benefits are permitted to commence under the plan, a QJSA must be offered that commences at the same time and that has an actuarial value that is at least as great as any other form of benefit payable under the plan at the same time. A married participant can choose to receive retirement

benefits in a form other than a QJSA if the participant;s spouse agrees in writing to that choice.

2. Qualified Preretirement Survivor Annuity

Federal law generally requires that defined benefit plans and certain defined contribution plans pay a monthly survivor benefit to surviving spouse for the spouse's life when a married particpant dies prior to the participan'ts annuity starting date, to the extent the participant's benefit is nonforfeitable under the terms of the plan at the time of his or her death. This benefit is called a qualified preretirement survivor annuity, or QPSA. As a general rule, an individual loses the right to the QPSA survivor benefits when he or she is divorced from the participant. However, if a former spouse is treated as the participant's surviving spouse under a QDRO, the former spouse is eligible to receive the QPSA unless the former spouse consents to the waiver of the QPSA. If the spouse deos not waivee the QPSA, the plan allow the spouse to receive the value of the QPSA in a form other than an annuity.

3. Defined Contribution Plans Not Subject to the QJSA or QPSA Requirements

Those defined contribution plans that are not required to pay benefits to married participants in the form of a QJSA or a QPSA are required by Federal law to pay the balance remaining in the participant's account after the participant dies to the participant's surviving spouse. If the spouse gives written consent, the particpant can direct that upon his or her death the account will be paid to a beneficiary other than the spouse, for example, the couple's children.

4. Alternate Payee Treated as Spouse

A QDRO may provide that an alternate payee who is a former spouse of the particpant will be treated as the particpan'ts spouse for some or all of the benefits payable upon the participant's death, so that the alternate payee will receive benefits provided to a spouse under the plan. To the extent that a former spouse is to be treated under the plan as the particpant's spouse pursuant to a QDRO, any subsequent spouse of the participant cannot be treated as the participant's surviving spouse. Thus, QDRO drafters should consider the potential impact of designating a former spouse as the participan'ts spouse on the disposition of survivor benefits among the former spouse and any subsequent spouse of the participant, as well as the impact on children or any other beneficiaries designated by the participant in accordance with the terms of the plan.

In determining the portion of the participant's benefits for which the altherantae payee is treated as the spouse, the drafters should take into account the manner in which benefits are otherwise divided under the QDRO. In particular, consideration shou.ld be given to whether the formula for dividing

the participant's benefits for this purpose should be coordinated with the formula otherwise used for dividng the benefits.

Under a defined benefit plan, or a defined contribution plan that is subjet to the QJSA and QPSA requirements, to the extent the former spouse is treated as the current spouse, the former spouse must consent to payment of retirement benefits in a form other than a QJSA or to the participant's waiver of the QPSA. For example, in a defined benefit plan, the participant would not be able to elect to receive a lump sum payment of the retirement benefits for which the alternate payee is treated as the participant's spouse unless the alternate payee consents. Similarly, the former spouse's consent might be required for any loan to the participant from the plan that is secured by his or her retirement benefits. In a defined contribution plan that is not subject to the QJSA and QPSA requirements, to the extent the QDRO treats the former spouse as thee participant's spouse under the plan, the esurvivor benefits under the plan must be paid to the former spouse unless he or she consents to have those benefits paid to someone else.

F. TAX TREATMENT OF BENEFIT PAYMENTS MADE PURSUANT TO A QDRO

The Federal income tax treatment of retirement benefits is governed by Federal law, and a QDRO canot designate who will be liable for the taxes owed when retirement benefits are paid. For a description of the tax consequences of payments to an alternate payee pursuant to a QDRO, see Internal Revenue Service Publication 575, Pension and Annuity Income. A local IRS office can provide this publication, or it may be obtained by calling 1-800-TAX-FORM.

Part II. SAMPLE LANGUAGE FOR INCLUSION IN QDRO

A. SAMPLE LANGUAGE FOR IDENTIFICATION OF PARTICIPANT AND ALTERNATE PAYEE

The "Participant" is [insert name of Participant]. The Participant's address is [insert Participant's address]. The Participant's social security number is [insert Participant's social security number].

The "Alternate Payee" is [insert name of Alternate Payee]. The Alternate Payee's address is [insert Alternate Payee's address]. The Alternate Payee's social security number is [insert Alternate Payee's social security number]. The Alternate Payee is the [describe the Alternate Payee's relationship to Participant] of the Participant.

B. SAMPLE LANGUAGE FOR IDENTIFICATION OF RETIREMENT PLAN

This order applies to benefits under the [insert formal name of retirement plan] ("Plan").

C. AMOUNT OF BENEFITS TO BE PAID TO ALTERNATE PAYEE

Instruction: The QDRO should clearly specify the amount or percentage of benefits assigned to the Alternate Payee or the manner in which the amount or percentage is to be determined, and the number of payments or period to which the Order applies. There are many different forms in which benefits may be paid from a qualified plan. Because of the diversity of factors that should be considered, and the need to tailor the assignment of benefits under a QDRO to meet the needs of the parties involved, specific sample language regarding the assignment of benefits has not been provided. See the discussion in Part I for further information.

D. SAMPLE LANGUAGE FOR FORM AND COMMENCEMENT OF PAYMENT TO ALTERNATE PAYEE

Instruction: Drafters using the separate interest approach may use paragraph 1. Drafters using the shared payment approach may use paragraph 2. Drafters using the separate interest approach for a portion of the benefits allocated to the alternate payee and the shared payment approach for the remainder should modify the sample language to specify the benefits to which each paragraph provided below applies..

1. Separatee Intereest Approach

The Alternate Payee may elect to receive payment from the Plan of the benefits assigned to the Alternate Payee under this Order in any form in which such benefits may be paid under the Plan to the Participant (other than in the form of a joint and survivor annuity with respect to the Alternate Payee and his or her subsequent spouse), but only if the form elected complies with the minimum distribution requirements of § 401(a)(9) of the Internal Revenue Code. Payments to the Alternate Payee pursuant to this Order shall commence on any date elected by the Alternate Payee (and such election shall be made in accordance with the terms of the Plan), but not earlier than the Participant's earlies retirement age (or such earlier date as allowed under the terms of the Plan), and not later than the earlier of (A) the date the Participant would be required to commence benefits under the terms of the Plan or (B) the latest date permitted by § 401(a)(9) of the Internal Revenue Code. For purposes of this Order, the eParticipant's earliest retirement age shall be the earlier of (i) the date on which the participant is entitled to a distribution under the Plan, or (ii) the later of (I) the date the Participant attains age 50, or (II) the earliest date on which the Participant could begin receiving benefits under the plan if the Participant separated from service.

2. Shared Payment Approach

The Alternate Payee shall receive payments from the Plan of the benefits assigned to the Alternate Payee under this Order (including payments attributable to the period in which the eissue of whether this Order is a qualified domestic relations order is beign determined) commencing as soon as practicable after this Order has been determined to be a qualified domestic relations order or, if later, on the date the Participant commences receiving benefit payments from the Plan. Payment to the Alternate Payee shall cease on the earlier of: [insert date or future event, such as the Alternate Payee's remarriage], or the date that payments from the Plan with respect to the Participant cease.

E. SAMPLE LANGUAGE FOR TREATMENT OF FORMER SPOUSE AS PARTICIPANT'S SPOUSE

Instruction: The Alternate Payee may be treated as the Participant's spouse only if theAlternate Payee is the Particpant's spouse or former spouse, and not if thee Alternate Payee is a child or other dependent of the Participant.

If the Alternate Payee is the Participant's spouse or former spouse, drafters may select sample paragraph 1, sample paragraph 2, or sample paragraph 3. Sample paragraph 1 applies if the Alternate Payee is treated as the Participant spouse for all of the spousal survivor benefits payable with respect to the Participant's benefits under the Plan. Sample paragraph 2 applies if the Alternate Payee is treated as the Participant's spouse for a portion of the spousal survivor benefits payable with respect to the Participant's benefits under the Plan. Sample paragraph 3 applies if the Alternate Payee is not treated as the Participant's spouse for any of the spousal survivor benefits payable with respect to the Participant's benefits under the Plan.

1. Alternate Payee Treated as Spouse For All Spousal Survivor Benefits

The Alternate Payee shall be treated as the Participant's spouse under the Plan for purposes of § § 401(a)(11) and 417 of the Code.

2. Alternate Payee Treated as Spouse For a Portion of the Spousal Survivor Benefits

The Alternate Payee shall be treated as the Participant's spouse under the Plan for purposes of § § 401(a)(11) and 417 of the Code with respect to [insert percentage of benefit or a formula, such as a formula describing the benefit earned under the plan during marriage].

3. Alternate Payee not Treated as Spouse

The Alternate Payee shall not be treated as the Participant's spouse under the Plan.

Griffin v. Griffin

Court of Appeals of Virginia

January 28, 2014, Decided

Record No. 1177-13-1

Reporter
62 Va. App. 736 *; 753 S.E.2d 574 **; 2014 Va. App. LEXIS 16 ***; 2014 WL 287906

SANDRA D.T. GRIFFIN v. DAVID L. GRIFFIN, DECEASED, C/O KIMBERLY COWSER-GRIFFIN, EXECUTRIX OF THE ESTATE OF DAVID L. GRIFFIN

Subsequent History: Appeal granted by *Cowser-Griffin v. Griffin, 2014 Va. LEXIS 113 (Va., Sept. 8, 2014)*

Affirmed by *Cowser-Griffin v. Griffin, 289 Va. 189, 771 S.E.2d 660, 2015 Va. LEXIS 15 (Feb. 26, 2015)*

Prior History: [*1]** FROM THE CIRCUIT COURT OF SUSSEX COUNTY. W. Allan Sharrett, Judge.

Griffin v. Cowser-Griffin, 2012 Va. Cir. LEXIS 192, 85 Va. Cir. 435 (Oct. 11, 2012)

Disposition: Reversed and remanded.

Counsel: J. Roger Griffin, Jr. (Christie, Kantor, Griffin, Smith & Harris, P.C., on brief), for appellant.

W. Hunter Old (Christopher T. Page; Kaufman & Canoles, P.C., on brief), for appellee.

Judges: Present: Judges Humphreys, Beales and Huff. OPINION BY JUDGE ROBERT J. HUMPHREYS. Huff, J., dissenting.

Opinion by: ROBERT J. HUMPHREYS

Opinion

[*742] [577]** OPINION BY JUDGE ROBERT J. HUMPHREYS.

Sandra D.T. Griffin ("Mrs. Griffin") appeals the order of the Circuit Court of Sussex County ("circuit court") denying her **[*743]** request for entry of a qualified domestic relations order ("QDRO"), which she pursues so that a certain term of her prior divorce decree might be enforced. For the following reasons, we reverse the circuit court's order.

I. BACKGROUND

"When reviewing a [circuit] court's decision on appeal, we view the evidence in the light most favorable to the prevailing party, granting it the benefit of any reasonable inferences." *Congdon v. Congdon, 40 Va. App. 255, 258, 578 S.E.2d 833, 835 (2003)*. However, the facts relevant to the resolution of this appeal are undisputed.

David L. Griffin ("Mr. Griffin") and Mrs. Griffin were married on March 20, 1987 and **[***2]** had two children, James J. Griffin, III, born on October 25, 1987, and Gloria D. Griffin, born on July 6, 1992. The parties were divorced by a final decree of divorce entered in the circuit court on August 12, 1998. The final decree of divorce ("final decree") incorporated the Separation and Property Settlement Agreement (hereinafter, "PSA" or "Agreement") entered into by the parties on August 30, 1996. The Agreement term that is the subject of this appeal reads: "The parties agree to name the children of the marriage as co-beneficiaries under all 401K Plans and other such plans which would be distributed upon the death of either party."

At the time of his death, Mr. Griffin was employed by Dominion Virginia Power ("Dominion"). At Dominion, he qualified for retirement benefits and he elected a 401(k) plan, known as Dominion's Salaried Savings Plan ("Salaried Savings Plan" or "Plan"), which is governed by the Employee Retirement Income Security Act ("ERISA"). The Salaried Savings Plan is a defined contribution plan designed to encourage retirement savings. Dominion's contributions to the plan depend on the participant's contributions and years of service. There is no actuarial analysis **[***3]** to determine the participant's benefits, and the participant's life expectancy is not a consideration in the Salaried Savings Plan. Under the Salaried Savings **[*744]** Plan, the surviving spouse is the beneficiary upon the participant's death unless she has consented to another beneficiary. The Salaried Savings Plan documents also provide that "if you are divorced, benefit payments from the Pension Plan or Savings Plan may be made to your former spouse, your child, or other dependent only in response to a Qualified Domestic Relations Order (QDRO)." The Dominion Plan Administrator testified that the Salaried Savings Plan is not a survivor annuity and it is strictly payable to the designated beneficiary.

In 2002, Mr. Griffin had named his children as his beneficiaries. However, Mr. **[**578]** Griffin married Kimberly Cowser-Griffin ("Cowser-Griffin") in 2007, and in 2008 Mr. Griffin named Cowser-Griffin as

his beneficiary for most of his funds, including the Salaried Savings Plan.[1] He named his children only as contingent beneficiaries on the Salaried Savings Plan. Shortly after his marriage to Cowser-Griffin, Mr. Griffin was diagnosed with renal cell cancer. He died on May 26, 2012. He had not retired from **[***4]** Dominion. No party had applied for a QDRO or notified the Dominion Plan Administrator of an alternate payee for the Salaried Savings Plan. In October 2012, Mrs. Griffin sent a draft QDRO to Dominion. Dominion's Plan Administrator responded that the proposed domestic relations order ("DRO") would not be treated as a QDRO in light of *Board of Trustees of the Indiana State Council of Plasterers & Cement Masons Pension Fund v. Steffens, Case **[*745]** No. 4:12CV513 JCH, 2012 U.S. Dist. LEXIS 151249 (E.D. Mo. 2012)*, a case concerning a domestic relations order entered after the plan participant's death. However, Dominion continued an administrative hold on Mr. Griffin's Salaried Savings Plan benefits pending the outcome of the litigation concerning the proper beneficiary under the Plan.

The circuit court ruled that it had jurisdiction to reinstate the parties' divorce case upon the docket "for such purposes as may be necessary to grant full relief to all parties," citing *Code § 20-121.1*, and that *Code § 20-107.3(K)* grants the circuit court continuing authority and jurisdiction "to make any additional orders necessary to effectuate and enforce any order entered pursuant to [equitable distribution]." The circuit court clarified that if it were to enter the QDRO it would not be modifying the final decree's incorporation of the property settlement agreement, "but rather would effectuate and **[***6]** enforce such an order by entry of a QDRO." However, the circuit court denied Mrs. Griffin's request to enter a proposed QDRO, finding that "under controlling federal law, without a preexisting QDRO, Mr. Griffin's retirement benefits in the Dominion Salaried Savings Plan vested entirely in the designated beneficiary and surviving spouse, [Cowser-Griffin], once the plan participant passed away." The circuit court found that under federal case law,

> at the time of retirement or preretirement death the former spouse must have perfected a QDRO at the time the benefits became payable, or that in order to effect a postmortem qualification of the domestic relations order ("DRO") as a QDRO, there must have been a DRO awarding the interest in the pension plan and substantially complying with ERISA's QDRO specificity requirements at the time the benefits became payable. Alternatively, Ms. Sandra Griffin could have put the plan on notice of her children's interest in the benefits. Ms. Griffin failed to perfect a QDRO prior to Mr. Griffin's passing, and the final decree of divorce and the PSA do not qualify as a QDRO. Further, there is no evidence in the record that any notice of the children's potential **[***7]** claim under the PSA was ever provided to the **[*746]** Plan at any time before the plan participant's death. Thus, Defendant's Motion for Entry of the [QDRO] is denied.

Mrs. Griffin timely appealed to this Court.

II. ANALYSIS

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[1] Mr. Griffin also had a special retirement account that was included as part of his Dominion Power Pension Plan. The special retirement account goes to the named beneficiary if the participant dies before retirement. Mr. Griffin named Cowser-Griffin as the beneficiary of the special retirement account.

In Mrs. Griffin's original motion before the circuit court, she stated that both the Salaried Savings Plan and the special retirement account under **[***5]** his Pension Fund are both subject to a QDRO and the focus of her motion. However, the proposed QDRO only names the Salaried Savings Plan, and not the Dominion Power Pension Plan or special retirement account that Mrs. Griffin mentions in her original motion and her brief. The circuit court only addressed the Dominion Salaried Savings Plan, and Mrs. Griffin did not note any specific objection stating that the circuit court failed to address additional plans or funds. Therefore, we only address the Dominion Salaried Savings Plan as it was the only plan addressed in the proposed QDRO.

Mrs. Griffin's assignment of error is that "[t]he trial court erred in ruling that the court could not properly enter a qualified domestic relations order under the circumstances **[**579]** of the case." "We review the [circuit] court's statutory interpretations and legal conclusions *de novo*." *Navas v. Navas, 43 Va. App. 484, 487, 599 S.E.2d 479, 480 (2004)* (quoting *Sink v. Commonwealth, 28 Va. App. 655, 658, 507 S.E.2d 670, 671 (1998))*.

The disbursement of Mr. Griffin's Salaried Savings Plan falls under the federal Employee Retirement Income Security Act of 1974 ("ERISA"), *29 U.S.C. § 1001 et seq.*, as stated in the Salaried Savings Plan documents and because it is an "employee pension benefit plan" as defined in *29 U.S.C. § 1002(2)*. An "employee pension benefit plan" or "pension plan" includes a plan maintained by an employer that provides retirement income to employees or deferred income for employees regardless of the method of calculating the benefits under the plan or the method **[***8]** of distributing benefits from the plan. *29 U.S.C. § 1002(2)*.

The principal goal of ERISA is to provide "a set of standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff v. Egelhoff, 532 U.S. 141, 148, 121 S. Ct. 1322, 149 L. Ed. 2d 264 (2001)*. *29 U.S.C. § 1144(a)* provides that the Act "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." The legislative intent behind ERISA was to establish a uniform administrative scheme governing employee benefit plans to prevent the employer from being subject to differing regulatory requirements in differing states. *Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9, 107 S. Ct. 2211, 96 L. Ed. 2d 1 (1987)*. The United States Supreme Court has "not hesitated to enforce ERISA's pre-emption **[*747]** provision where state law created the prospect that an employer's administrative scheme would be subject to conflicting requirements." *Id. at 10*.

A. *29 U.S.C. § 1055* Does Not Apply to the Salaried Savings Plan

Congress enacted the Retirement Equity Act of 1984 ("REA") which "enlarged ERISA's protection of surviving spouses in significant respects." *Boggs v. Boggs, 520 U.S. 833, 843, 117 S. Ct. 1754, 138 L. Ed. 2d 45 (1997)*. The enlarged protections in REA are codified in *29 U.S.C. § 1055*. **[***9]** Pursuant to the statutory language, *29 U.S.C. § 1055* applies to,

> (A) any defined benefit plan,
>
> (B) any individual account plan which is subject to the funding standards of section 302 [*29 USCS § 1082*], and
>
> (C) any participant under any other individual account plan[2] *unless*—
> (i) such plan provides that the participant's non-forfeitable accrued benefit (reduced by any security interest held by the plan by reason of a loan outstanding to such participant) is payable in full, on the death of the participant, to the participant's surviving spouse (or, if there is no surviving spouse or the

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[2] The term "individual account plan" or "defined contribution plan" means a pension plan which provided for an **[***11]** individual account for each participant and for benefits based solely upon the amount contributed to the participant's account, and any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to such participant's account.

29 U.S.C. § 1002(34).

> surviving spouse consents in the manner required under subsection (c)(2), to a designated beneficiary),[3]
>
> **[*748]** (ii) such participant does not elect the payment of benefits in the form of a life annuity, and
>
> (iii) with respect to such participant, such plan is not a direct or indirect transferee (in a transfer after December 31, 1984) of a plan which is described in subparagraph (A) or (B) or to which this **[**580]** clause applied with respect to the participant.

29 U.S.C. § 1055(b)(1) (footnotes added). While *§ 1055* governs most pension plans with surviving spouse benefits, it provides an exception for some individual account **[***10]** plans. Mr. Griffin's estate concedes that the Dominion Salaried Savings Plan is one such plan excepted by the statutory language. Mr. Griffin's estate, however, relies on language from Boggs stating that *all* pension plans are governed by *§ 1055*, and thus, he argues that despite the statutory exception, the Salaried Savings Plan is nevertheless regulated by *§ 1055*.

> Congress' concern for surviving spouses is also evident from the expansive coverage of *§ 1055*, as amended by REA. *Section 1055*'s requirements, as a general matter, apply to all "individual account plans" and "defined benefit plans." *§ 1055(b)(1)*. The terms are defined, for *§ 1055* purposes, so that all pension plans fall within those two categories. See *§ 1002(35)*. While some individual account plans escape *§ 1055*'s surviving spouse annuity requirements under certain conditions, Congress still protects the interests of the surviving spouse by requiring those plans to pay the spouse the nonforfeitable accrued benefits, reduced by certain security interests, in a lump-sum payment. *§ 1055(b)(1)(C)*.

Boggs, 520 U.S. at 843.

First, we note that the above quoted language from Boggs is dicta and we note that, contrary to the assertion of Mr. Griffin's estate, the Boggs Court's choice of words actually is **[*749]** that *§ 1055* applies "*as a general matter* **[***12]** . . . to all 'individual account plans' and 'defined benefit plans.'" Id. (emphasis added). Thus, we do not read Boggs as a judicial revision of the statutory language designed to eliminate exceptions created by Congress. In Boggs, the pension plan at issue in the above quoted analysis was a "qualified joint and survivor annuity mandated by ERISA" in *29 U.S.C. § 1055(a)* and *(d)(1)*, *id. at 842*, and not an individual account plan as is the case here.[4] Because the Supreme Court was *not* faced with deciding whether a particular individual account plan fell within the statutory exception to *29 U.S.C. § 1055*, as provided in *§ 1055(b)(1)(C)*, the Court's interpretation that *§ 1055* applies to all individual

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[3] The chief point of contention between the majority and the dissent lies in the applicability of this latter parenthetical language. Contrary to the view of the dissent, we conclude that the language set off in these parentheses after the word "spouse" is inapplicable in this case because the Salaried Savings Plan "is payable in full, on the death of the participant, to the participant's surviving spouse." *29 U.S.C. § 1055(b)(1)(C)(i)*. The Salaried Savings Plan thus meets these requirements to be excepted from *§ 1055* application, and therefore we need not look past the opening parenthesis and immediately following "or" for other situations to which the exception applies.

[4] We note that the deceased plan participant in Boggs did receive a lump-sum distribution from his employer's savings plan upon his retirement. *Boggs, 520 U.S. at 836*. However, he rolled the lump sum distribution into an Individual Retirement Account ("IRA"), and the Court analyzed the proper beneficiary of the IRA separately **[***13]** from the qualified joint and survivor monthly annuity payments payable to the surviving spouse from the employer's retirement program. The Court addressed the qualified joint and survivor annuity with a thorough analysis of *§ 1055* in Section III of the opinion, and while the IRA was addressed in the following section, the IRA was *not* addressed in the Court's *§ 1055* analysis. *Id. at 836-37, 842, 844-45*.

account plans is dicta and not binding precedent. See *Camreta v. Greene, 131 S. Ct. 2020, 2045, 179 L. Ed. 2d 1118 (2011)* (dicta remarks do not establish law or qualify as binding precedent).

The fact that *29 U.S.C. § 1055(b)(1)(C)* requires excepted plans to pay a surviving spouse the participant's nonforfeitable accrued benefits in a lump-sum payment does not mean that the other provisions of *§ 1055* apply to those plans. While *§ 1055(b)(1)(C)* does require *excepted* plans to pay a surviving spouse the participant's nonforfeitable accrued benefits in a lump-sum payment, this requirement is one of three to be met for an individual account plan to be excepted from *§ 1055*; it would be illogical to conclude that *§ 1055* applies to an individual account plan excepted by the language of the statute itself.

[*750] Additionally, the fact that the Salaried Savings Plan requires spousal consent in the same manner as provided in *29 U.S.C. § 1055(c)(2)* does not mean that *§ 1055* applies to the Plan. **[***14]** In fact, the statute itself contemplates that excepted plans may require spousal consent "in the manner required under *subsection (c)(2)*." *29 U.S.C. § 1055(b)(1)(C)(i)*. Accordingly, while an ERISA governed plan may require consent in the manner provided in *29 U.S.C. § 1055(c)(2)*, it may escape *§ 1055* application. Such is the case here where the Salaried Savings Plan requires spousal consent in **[**581]** the manner provided in *29 U.S.C. § 1055(c)(2)*. The Salaried Savings Plan meets *§ 1055*'s requirements for excepted plans because (1) the Plan provides that the participant's benefits are payable in full to the surviving spouse upon the participant's death, (2) Mr. Griffin did not elect to receive benefits in the form of a life annuity, and (3) there is no evidence or allegations that the Salaried Savings Plan is a transferee of a previous plan. Moreover, as stated *supra*, Mr. Griffin's estate concedes that the Salaried Savings Plan is excepted from *§ 1055* application. Therefore, the Plan is not subject to the regulations that apply to joint and survivor annuities and pre-retirement survivor annuities pursuant to *§ 1055*, nor does the case law interpreting the *§ 1055* annuity regulations apply.

B. **[***15]** ERISA Allows for Assignment or Alienation of Plan Benefits Pursuant to a QDRO

Turning to Mrs. Griffin's proposed QDRO, we must determine whether it meets the statutory requirements for a QDRO, and if it does, it is not pre-empted. *Boggs, 520 U.S. at 848*. In other words, enforceability of Mrs. Griffin's interest "ultimately depends on whether a state court order is qualified under ERISA." *Langston v. Wilson McShane Corp., 828 N.W.2d 109, 116 (Minn. 2013)*.

ERISA generally obligates administrators to manage ERISA plans "in accordance with the documents and instruments governing them." *29 U.S.C. § 1104(a)(1)(D)*. "At a more specific level, the Act requires covered pension benefit plans to 'provide that benefits . . . under the plan may not be **[*751]** assigned or alienated,' [*29 U.S.C.] § 1056(d)(1)*, but this bar does not apply to qualified domestic relations orders (QDROs), [*29 U.S.C.] § 1056(d)(3)*." *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 555 U.S. 285, 288, 129 S. Ct. 865, 172 L. Ed. 2d 662 (2009)*. "The QDRO provision is an exception not only to ERISA's rule against assignment of plan benefits but also to ERISA's broad preemption of state law." *Trs. of the Dirs. Guild v. Tise, 234 F.3d 415, 420 (9th Cir. 2000)* (citing *29 U.S.C. § 1144(b)(7)*). **[***16]** *29 U.S.C. § 1056(d)(3)(A)* provides,

> Paragraph (1) [stating benefits may not be assigned or alienated] shall apply to the creation, assignment, or recognition of a right to any benefit payable with respect to a participant pursuant to a domestic relations order, except that paragraph (1) shall not apply if the order is determined to be a

qualified domestic relations order. *Each pension plan shall provide for the payment of benefits in accordance with the applicable requirements of any qualified domestic relations order*.

(Emphasis added).

The Dominion Salaried Savings Plan provides under the heading "Death Benefits, Your Beneficiary":

> If you die while employed by Dominion, the entire value of your account is distributed to your beneficiary, including the value of all Company Matching contributions that automatically become vested upon your death.
>
> Federal law requires that, *if you are married when you die*, your spouse must receive the distribution unless she or he approved your choice of another (or an additional) beneficiary before your death. Your spouse must agree to your choice of that beneficiary by signing the spousal consent portion of a Beneficiary Authorization Form obtained from **[***17]** ACS. The form must have been completed, signed, notarized, and returned to ACS before your death.

However, the Salaried Savings Plan document includes the *29 U.S.C. § 1056(d)(3)(A)* requirement by stating: "if you are divorced, benefit payments from the Pension Plan or Savings Plan may be made to your former spouse, your child, or other **[*752]** dependent only in response to a Qualified Domestic Relations Order (QDRO)."

The term "domestic relations order" is defined as "any judgment, decree, or order (including approval of a property settlement agreement) which — (I) relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant, and (II) is made pursuant to a State **[**582]** domestic relations law . . . ." *29 U.S.C. § 1056(d)(3)(B)(ii)*. A "qualified domestic relations order" is a domestic relations order "which creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under a plan," and meets the requirements of subparagraphs (C) and (D):

> (C) A domestic relations order meets **[***18]** the requirements of this subparagraph only if such order clearly specifies—
>
> (i) the name and last known mailing address (if any) of the participant and the name and mailing address of each alternate payee covered by the order,
>
> (ii) the amount or percentage of the participant's benefits to be paid by the plan to each such alternate payee, or the manner in which such amount or percentage is to be determined.
>
> (iii) the number of payments or period to which such order applies, and
>
> (iv) each plan to which such order applies.
>
> (D) A domestic relations order meets the requirements of this subparagraph only if such order—
>
> (i) does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan,
>
> (ii) does not require the plan to provide increased benefits (determined on the basis of actuarial value), and
>
> (iii) does not require the payment of benefits to an alternate payee which are required to be paid to another **[*753]** alternate payee under another order previously determined to be a qualified domestic relations order.

29 U.S.C. § 1056(d)(3). If the DRO qualifies as a QDRO, then the person who is an alternate payee under the QDRO is considered a beneficiary under **[***19]** the plan. 29 U.S.C. § 1056(d)(3)(J).

The circuit court provided the following reasoning for denying entry of Mrs. Griffin's proposed QDRO: 1) The final decree and the PSA did not substantially comply with ERISA's QDRO specificity requirements at the time the benefits became payable, thus preventing a postmortem qualification of either DRO (the final decree or PSA) as a QDRO; 2) Mr. Griffin's retirement benefits in the Salaried Savings Plan vested entirely in Cowser-Griffin as the designated beneficiary and surviving spouse once Mr. Griffin died, and; 3) The Plan was not put on notice of alternate payees prior to the plan participant's death.

We hold that the circuit court erred in its analysis denying entry of the QDRO for the following reasons.

C. The QDRO is the Tool by which State Courts Can Enforce Marital Property Settlements

The Griffin PSA was incorporated into the final decree of divorce, and its terms should be enforced by the circuit court. The Code of Virginia provides for reinstatement of divorce suits to allow parties to obtain full relief:

> In any suit which has been stricken from the docket, and in which complete relief has not been obtained, upon the motion or application **[***20]** of either party to the original proceedings, the same shall be reinstated upon the docket for such purposes as may be necessary to grant full relief to all parties.

Code § 20-121.1. "[M]arital property settlements entered into by competent parties upon valid consideration for lawful purposes are favored in the law and such will be enforced unless their illegality is clear and certain." Derby v. Derby, 8 Va. App. 19, 25, 378 S.E.2d 74, 77, 5 Va. Law Rep. 2059 (1989) (quoting Cooley v. ***[*754]*** Cooley, 220 Va. 749, 752, 263 S.E.2d 49, 52 (1980)). More generally, "when a contract has been made, and either party refuses to perform the agreement, equity enforces the performance of the contract specifically, by compelling the refractory party to fulfill his engagement according to its terms." Dunsmore v. Lyle, 87 Va. 391, 392, 12 S.E. 610, 611 (1891). Thus, as the legality of the PSA incorporated into the final decree is uncontested, the circuit court is responsible for enforcing its terms under state law.

The parties agreed in the PSA to "name the children of the marriage as co-beneficiaries **[**583]** under all 401(k) plans and other such plans which would be distributed upon the death of either party." Although Mr. Griffin initially **[***21]** named his children as beneficiaries, he later changed the designated beneficiary on the Salaried Savings Plan to Cowser-Griffin and named the children only as contingent beneficiaries. Thus, Mr. Griffin clearly breached the terms of the PSA by naming Cowser-Griffin as the beneficiary to his Salaried Savings Plan.

When a party breaches the terms of a property settlement agreement by failing to name beneficiaries on ERISA-governed accounts in accordance with the agreement, the only way for the circuit court to enforce the agreement is to issue a QDRO. 29 U.S.C. § 1056(d)(3); Kennedy, 555 U.S. at 288 (ERISA prohibits assignment or alienation of benefits governed by the plan except in the case of a QDRO). "The QDRO provisions of ERISA do not suggest that a former spouse has no interest in the plans until she obtains a QDRO, they merely prevent her from enforcing her interest until the QDRO is obtained." Gendreau v. Gendreau, 122 F.3d 815, 819 (9th Cir. 1997). A spouse's "interest in the pension plans (or, at a minimum,

her right to obtain a QDRO which would in turn give her an interest in the plans) was established under state law at the time of the divorce decree." *Id. at 818*. "State family **[***22]** law can . . . create enforceable interests in the proceeds of an ERISA plan, so long as those interests are articulated in accord with the QDRO provision's requirements." *Tise, 234 F.3d at 420*; see also **[*755]** *Turner v. Turner, 47 Va. App. 76, 79, 622 S.E.2d 263, 265 (2005)* (this Court agreed with wife that the "QDRO simply was an administrative mechanism to effectuate the intent and purpose of the final decree's award").

D. A DRO May Be Revised to Meet the QDRO Requirements

While the PSA and final decree in this case do not meet the requirements of a QDRO, under state law a circuit court may make additional orders necessary to effectuate and enforce an order of the court. The circuit court has the authority to modify an order intended to affect or divide deferred compensation plans or retirement benefits for the purpose of establishing the order as a QDRO "or to revise or conform its terms so as to effectuate the expressed intent of the order." *Code § 20-107.3(K)(4)*. *Code § 20-107.3(K)(4)* "'permits the court to revise its orders to comply with language required by federal law to effectuate the intended pension award, but not to substantively change the pension award itself.'" *Craig v. Craig, 59 Va. App. 527, 539, 721 S.E.2d 24, 30 (2012)* **[***23]** (quoting *Irwin v. Irwin, 47 Va. App. 287, 297 n.8, 623 S.E.2d 438, 443 n.8 (2005))*.

Further, in the Pension Protection Act of 2006, Congress makes clear that a QDRO will not fail solely because the order is issued after, or revises, another domestic relations order; nor will it fail solely because of the time at which it is issued. Pub. L. No. 109-280, § 1001, 120 Stat. 780, 1001 (2006). Congress mandated that the Secretary of Labor issue regulations under ERISA to this end:

> Not later than 1 year after the date of the enactment of this Act, the Secretary of Labor shall issue regulations under section 206(d)(3) of the Employee Retirement Security Act of 1974 and *section 414(p) of the Internal Revenue Code of 1986* which clarify that—
>
> (1) *a domestic relations order otherwise meeting the requirements to be qualified domestic relations order . . .* ***[*756]*** *shall not fail to be treated as a qualified domestic relations order solely because—*
>
> > (A) *the order is issued after, or revises, another domestic relations order or qualified domestic relations order*; or
> > (B) of the time at which it is issued[.]

Id. (emphasis added). Thus, both the Pension Protection Act of 2006 and the Code of Virginia permit revisions **[***24]** to a DRO, as long as the revisions do not substantively change the award itself, in order to produce a QDRO.

In this case, it does not matter that the final decree and PSA were not QDROs because it is permissible under both federal and state law that an order issued after and revising these domestic relations orders **[**584]** can become a QDRO. Further, the proposed QDRO did not make any substantive changes to the benefits agreed upon in the final decree and PSA, the substantive portion of which is: "The parties agree to name the children of the marriage as co-beneficiaries under all 401K Plans and other such plans which would be distributed upon the death of either party." The proposed QDRO provides "The Alternate Payees [James J. Griffin, III, and Gloria D. Griffin] shall be entitled to One Hundred Percent (100%) of the Member's vested account under the Plan to be divided equally between them, fifty percent (50%) each."

The crux of both of these provisions is equal distribution of death benefits from the 401(k) Salaried Savings Plan to the children. While the DROs did not meet the specificity requirements of a QDRO, the purpose of the proposed QDRO is to meet these specificity requirements, **[***25]** as permitted by the federal and state laws.

E. The Proposed QDRO Meets ERISA's Specificity Requirements

The proposed QDRO meets the specificity requirements found in *29 U.S.C. § 1056(d)(3)*. The proposed QDRO includes the information required by *§ 1056(d)(3)(C)*: (1) the names and mailing addresses of Mr. Griffin, the plan participant, and his children, the alternate payees, (2) the percentage **[*757]** of benefits each alternate payee should be paid, fifty-percent each, (3) the number of payments to which the order applies, single cash sums or "such other form of distribution as may be elected by the Alternate Payees under the terms of the Plan," and (4) the plan to which the order applies, the interest of Mr. Griffin in the Dominion Salaried Savings Plan.

In accordance with *29 U.S.C. § 1056(d)(3)(D)(i)*, the proposed QDRO does not require the Salaried Savings Plan to provide a type or form of benefit, or any option, not otherwise provided under the Plan. The proposed QDRO seeks one hundred percent of the benefits vested in Mr. Griffin's Salaried Savings Plan in the form of a single cash sum or other distribution as the children may elect under the Plan. This is consistent with the Salaried Savings **[***26]** Plan which provides, "If you die while employed by Dominion, the entire value of your account is distributed to your beneficiary, including the value of all Company matching contributions that automatically become vested upon your death," and "Non-spousal Beneficiaries must elect to receive the balance of your Account in an immediate lump sum payment or in annual payments totaling the balance of your Account that conclude within five (5) years after the date of your death."

The fact that the proposed QDRO names beneficiaries other than Cowser-Griffin does not change the form of benefit. *29 U.S.C. § 1056(d)(3)(E)(i)(III)* provides,

> A domestic relations order shall not be treated as failing to meet the requirements of [*29 U.S.C. § 1056(d)(3)(D)(i)*] solely because such order requires that payment of benefits be made to an alternate payee . . . in any form in which such benefits may be paid under the plan to the participant (other than in the form of a joint and survivor annuity with respect to the alternate payee and his or her subsequent spouse).

Here, the Salaried Savings Plan is not a joint and survivor annuity, but rather a defined contribution plan.[5] See *29 U.S.C. § 1002(34)*. **[*758]** Also, the **[***27]** Plan allowed Mr. Griffin to receive the entire

[5] A "qualified joint and survivor annuity" is an annuity

> for the life of the participant with a survivor annuity for the life of the spouse which is equal to the applicable percentage of the amount of the annuity which is payable during the joint lives of the participant and the spouse, and (ii) which is the actuarial equivalent of a single annuity for the life of the participant. Such term also includes any annuity in the form having the effect of an annuity described in the preceding sentence.

29 U.S.C. § 1055(d). The Salaried Savings Plan is not an annuity and is not based on actuarial calculations; it is a defined contribution plan. The Plan benefits are based on the participant's contributions, Dominion's matching contributions, and the investment earnings on the contributions. A specific retirement **[***28]** benefit is not guaranteed; rather the Salaried Savings Plan is designed to encourage retirement savings.

balance of his account at any time after his retirement. **[**585]** Thus, the request in the proposed QDRO for the children, and not Cowser-Griffin, to receive payment of the benefits, in lump sum or other option available to them under the Plan, does not run afoul of the requirement that the QDRO only require a form of benefit already provided by the Plan.

The regulations issued by the Department of Labor pursuant to the Pension Protection Act of 2006 in the form of illustrative examples, apply to this case,[6] and Examples 1 and 4 of *29 C.F.R. § 2530.206(d)* specifically support the conclusion that the proposed QDRO in this case conforms to the "type or form of benefit" requirement of *29 U.S.C. § 1056(d)(3)(i)*. In *29 C.F.R. § 2530.206(d)(2)*(ex. 1) the "Participant and Spouse divorce, and their divorce decree provides that the parties will prepare a [DRO] assigning 50 percent of Participant's benefits under a 401(k) plan to Spouse to be paid in monthly installments over a 10-year period." Participant then dies while actively employed. Id. "A [DRO] consistent with the divorce decree is subsequently submitted to the 401(k) plan; however, **[*759]** the plan does not provide for 10-year installment payments of the type described in the order." Id. The example provides that "the order does not fail to be treated as a QDRO solely because it is issued after the death of Participant, but the order would fail to be a QDRO . . . because the order requires **[***29]** the plan to provide a type or form of benefit, or any option, not otherwise provided under the plan." Id.

The example provided in *29 C.F.R. § 2530.206(d)(2)*(ex. 4) is also applicable to this case: Participant retires and begins receiving benefit payments in the form of a straight life annuity based on the life of participant, and spouse waived her surviving spousal rights. Participant then divorces spouse after the annuity start date and presents the plan with a DRO "that eliminates the straight life annuity based on Participant's life and provides for Spouse, as alternate payee, to receive all future benefits in the form of a straight life annuity based on the life of Spouse. The plan does not allow reannuitization with a new annuity starting date." Id.

> [T]he order does not fail to be a QDRO solely **[***30]** because it is issued after the annuity starting date, but the order would fail to be a QDRO . . . because the order requires the plan to provide a type or form of benefit, or any option, not otherwise provided under the plan. However, the order would not fail to be a QDRO . . . if instead it were to require all of Participant's future payments under the plan to be paid instead to Spouse, as an alternate payee (so that payments that would otherwise be paid to the Participant during the Participant's lifetime are instead to be made to the Spouse during the Participant's lifetime).

Id.

In this case, the relevant benefit is the funds in a 401(k) payable in a lump sum, which is essentially what the proposed QDRO requests to be paid to the children. The proposed QDRO does not call for a change in the type or form of benefit such as payment over a term not offered by the Plan or a reannuitization not allowed under the Plan.

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[6] Where Congress has expressly delegated authority to an agency to elucidate a specific provision of a statute by regulation as it did in the Pension Protection Act of 2006, as cited *supra*, "[s]uch legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Chevron, U.S.A., Inc. v. NRDC, Inc., 467 U.S. 837, 843-44, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984)*.

[*760] The proposed QDRO also meets the last two requirements in *29 U.S.C. § 1056(d)(3)(D)*. It does not call for the Plan to provide increased benefits determined on actuarial values, *29 U.S.C. § 1056(d)(3)(D)(ii)*, as Mr. Griffin's Salaried Savings Plan benefits were not based on **[***31]** actuarial calculations, but only the sum of his contributions, Dominion's matching contributions, and the investment earnings on those contributions. Further, the proposed QDRO does not require the payment of benefits to an alternate payee which are required to be paid to another alternate payee pursuant to a previously entered QDRO, *29 U.S.C. § 1056(d)(3)(D)(iii)*, as there is no previously entered QDRO in this case.

[586]** F. The Timing of the Proposed QDRO Does Not Cause it to Fail

The fact that the proposed QDRO was not entered before the circuit court or to the Plan until after Mr. Griffin's death does not cause it to fail. As previously mentioned, in the Pension Protection Act of 2006 Congress ordered the Secretary of Labor to enter regulations clarifying that a DRO shall not fail to be treated as a QDRO solely because of the time at which it issued. *29 C.F.R. § 2530.206(c)* gives examples illustrating how a DRO shall not fail to be treated as a QDRO solely because of the time at which it is issued. *29 C.F.R. § 2530.206(c)(2)*(ex. 1) provides that a QDRO does not fail to be treated as a QDRO solely because it is issued after the death of the participant who died while actively employed and **[***32]** the order was subsequently submitted to the plan:

> Example (1). Orders issued after death. Participant and Spouse divorce, and the administrator of Participant's plan receives a domestic relations order, but the administrator finds the order deficient and determines that it is not a QDRO. Shortly thereafter, Participant dies while actively employed. A second domestic relations order correcting the defects in the first order is subsequently submitted to the plan. The second order does not fail to be treated as a QDRO solely because it is issued after the death of the Participant. The result would be the same even if no order **[*761]** had been issued before the Participant's death, in other words, the order issued after death were the only order.

Thus, in the present case, the proposed QDRO should not fail solely because it was not entered prior to Mr. Griffin's death, and the fact that the Plan was not on notice of an alternate payee is of no consequence according to the last sentence of the instruction example in the applicable federal regulation.

G. The Plan Benefits Did Not Vest in Cowser-Griffin upon Mr. Griffin's Death

The circuit court concluded that "under controlling federal law" Mr. Griffin's **[***33]** retirement benefits in the Salaried Savings Plan vested entirely in Cowser-Griffin at the moment of Mr. Griffin's death. However, federal law does not dictate that the benefits vested in Cowser-Griffin at Mr. Griffin's death; rather, ERISA generally obligates administrators to manage ERISA plans "in accordance with the documents and instruments governing them." *29 U.S.C. § 1104(a)(1)(D)*. In this case, the Salaried Savings Plan documents only refer to "vesting" in terms of benefits vesting in the participant's account. The Salaried Savings Plan does not address the vesting of benefits in a spouse or other beneficiary, but rather defines vesting as the participant's "non-forfeitable right to part or all of the value of [his] account." The Plan states that the participant is "always vested in the value of [his] employee Pre-tax, After-tax, and Rollover contributions and the investment earnings on those contributions," and is vested in company matching contributions and their earnings after three years of service. While the Plan requires spousal consent for a participant to designate a beneficiary other than his current spouse as the recipient of the

funds vested in the participant's account, **[***34]** it also provides that a QDRO may assign the participant's Salaried Savings Plan benefits to a former spouse, child, or other dependent.

Moreover, ERISA contemplates situations where a benefit becomes payable, but a court or the plan administrator takes months to determine if a DRO qualifies as a QDRO. *29 U.S.C. § 1056(d)(3)(H)* provides:

> **[*762]** (i) During any period in which the issue of whether a domestic relations order is a qualified domestic relations order is being determined (by the plan administrator, by a court of competent jurisdiction, or otherwise), the plan administrator shall separately account for the amounts (hereinafter in this subparagraph referred to as the "segregated amounts") which would have been payable to the alternate payee during such period if the order had been determined to be a qualified domestic relations order.
>
> (ii) If within the 18-month period described in clause (v) the order (or modifications thereof) is determined to be a qualified domestic relations order, the plan **[**587]** administrator shall pay the segregated amounts (including any interest thereon) to the person or persons entitled thereto.
> * * * * * * *
>
> (iv) Any determination that an order is a qualified domestic **[***35]** relations order which is made after the close of the 18-month period described in clause (v) shall be applied prospectively only.

Thus, a proposed QDRO does not automatically fail solely because a benefit has become payable and the correct beneficiary or beneficiaries are not yet determined. This statute provides for the situation of this case where a QDRO would be presented to the plan administrator after benefits become payable and the proper beneficiary is not yet determined or may have to be re-determined; this runs contrary to the circuit court's finding that benefits automatically vest in the surviving spouse where there is no preexisting QDRO.[7] The court in Tise likewise interpreted *29 U.S.C. § 1056(d)(3)(H)*: "the statute necessarily permits an alternate payee who has obtained a state law DRO before the plan participant's retirement, death, or other benefit-triggering event to perfect the **[*763]** DRO into a QDRO thereafter (subject to the 18-month period after which any previously-due benefits are payable to the original beneficiary)." *Tise, 234 F.3d at 422-23*.

Hopkins v. AT&T Global Information Solutions Co., 105 F.3d 153 (4th Cir. 1997), is the case Mr. Griffin's estate relies on as the "keystone case on the issue of vested rights for surviving spouses." Hopkins is easily distinguishable from the present case because of the form of benefit at issue in the case. In Hopkins, husband retired and began receiving pension benefits in the form of a qualified joint and survivor annuity, where he received a fixed income for his life ("pension benefits"), and if his spouse at retirement survived him, she would receive 50% of that fixed income for the remainder of her life ("surviving spouse benefits"). *Id. at 154-55*. Also, if husband died prior to retirement, pension benefits would be paid to his spouse as preretirement survivor annuity. *Id. at 155 n.1*. Husband's former spouse sought judgment to collect alimony against husband's pension benefits and against his current spouse's (also his spouse at retirement) surviving spouse benefits. The state court granted two judgment orders, one

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[7] Our analysis is confined to the Salaried Savings Plan at issue in this case, to which *29 U.S.C. § 1055* does not apply. We recognize **[***36]** that different vesting rules may apply to joint and survivor annuities, preretirement survivor annuities, or other plans to which *29 U.S.C. § 1055* does apply.

against **[***37]** the pension benefits and one against the surviving spouse benefits. *Id. at 155*. AT&T conceded that the order concerning the pension benefits was a QDRO, but argued that "because the Surviving Spouse Benefits had already vested in [the current spouse], the Surviving Spouse Order is not a QDRO." Id.

The Fourth Circuit noted that the question of whether a participant's current spouse has a vested interest in the surviving spouse benefits is a question of first impression on the federal courts and pointed out that ERISA does not explicitly state when a current spouse's interest in the surviving spouse benefits vests. *Id. at 156*. "However, after carefully reviewing the overall framework of ERISA, especially the provisions governing joint and survivor annuities, we conclude that the Surviving Spouse Benefits vest in the participant's current spouse on the date the participant retires." Id. The Hopkins court relied on the strict regulations that specifically apply to joint and survivor annuities and the accompanying **[*764]** surviving spouse benefits set forth in *29 U.S.C. § 1055* as support for its holding that the participant's spouse at the time of retirement has a vested interest in the surviving **[***38]** spouse benefits. *Id. at 156-57*. The court also noted that because the disbursement of the plan benefits is "based on actuarial computations, the plan administrator must know the life expectancy of the person receiving the Surviving Spouse Benefits to determine the participant's monthly Pension Benefits. As a result, the plan administrator needs to know, on the day the participant retires, to whom the Surviving Spouse Benefits is payable." *Id. at 157 n.7*. Additionally, the court noted that a former spouse could obtain an interest in the **[**588]** participant's pension benefits by obtaining a QDRO at any time, as the former spouse did. *Id. at 157*.

As the surviving spouse benefits in Hopkins were a product of a joint and survivor annuity regulated by *29 U.S.C. § 1055*, Hopkins is not persuasive on the subject of vesting as Mr. Griffin's estate suggests because the Salaried Savings Plan is exempted from *§ 1055* application. Further, unlike the plan in Hopkins, Mr. Griffin's Salaried Savings Plan benefits do not depend on actuarial calculations of the life of Mr. Griffin or Cowser-Griffin, or provide defined retirement benefits to Cowser-Griffin for the span of her life as predicted at Mr. Griffin's **[***39]** death or retirement.

Mr. Griffin's estate also relies on *Carmona v. Carmona, 544 F.3d 988 (9th Cir. 2008)*, to support his argument that Mr. Griffin's benefits vested in Cowser-Griffin on the date of his death. However, like Hopkins, the benefits at issue in Carmona are qualified joint survivor annuity benefits. The court concluded, "once a participant retires, the spouse at the time becomes the 'surviving spouse' entitled to the QJSA benefits." *Id. at 1002*. "ERISA's surviving spouse benefits established in *section 1055* were created in part 'to ensure a stream of income to surviving spouses.'" Id. (quoting *Boggs, 520 U.S. at 843*). Once again, the Salaried Savings Plan benefits at issue in this case do not qualify as surviving spouse annuity benefits established in *29 U.S.C. § 1055*.

[*765] The United States Court of Appeals for the Ninth Circuit in *Hamilton v. Washington State Plumbing & Pipefitting Industry Pension Plan, 433 F.3d 1091 (9th Cir. 2006)*, has also distinguished treatment of surviving spouse benefits regulated by *29 U.S.C. § 1055* from a participant's pension benefits upon his retirement or death. The court found that the rights of a surviving spouse to a preretirement survivor annuity, **[***40]** governed by *29 U.S.C. § 1055*, are available only to a surviving spouse or a former spouse properly designated, but not available to children as alternate payees pursuant to a QDRO. *Id. at 1101*. However, the court noted that "designating children in a QDRO as alternate payees under a pension plan can provide a myriad of potential benefits to the children, depending on their ages, the date of the participant's disability, retirement, or death, and the participant's marital status." Id. Thus, the court

distinguished the effectiveness of a QDRO entered against surviving spouse annuities regulated by *29 U.S.C. § 1055* and other pension benefits that are not *§ 1055* surviving spouse annuities.

The Tise court also drew a distinction between a participant's pension benefits, which were at issue before the court, and surviving spouse benefits pursuant to *29 U.S.C. § 1055*:

> Whether a QDRO issued after a plan participant's retirement may affect the distribution of surviving spouse benefits pursuant to *29 U.S.C. § 1055* implicates statutory provisions and policy considerations other than those here applicable. See [*Hopkins, 105 F.3d at 156-57*]; *Rivers v. Central & South West Corp., 186 F.3d 681, 683-84 (5th Cir. 1999)*. **[***41]** We therefore leave to a case concerning *§ 1055* the determination whether, as Hopkins and Rivers determined, the plan participant's retirement cuts off a putative alternate payee's right to obtain an enforceable QDRO substituting the alternate payee for the surviving spouse with regard to statutory surviving spouse benefits.

Tise, 234 F.3d at 422 n.6.

In the Commonwealth, it is well established that "'property rights and interests [become] vested in the parties **[*766]** when they [agree] upon them, set them forth in a valid separation agreement, and [have] them incorporated into their final divorce decree.'" *Irwin, 47 Va. App. at 294, 623 S.E.2d at 441* (quoting *Himes v. Himes, 12 Va. App. 966, 970, 407 S.E.2d 694, 697, 8 Va. Law Rep. 303 (1991))*. "Such an agreement creates vested property rights in the parties by virtue of the judicial sanction and determination of the court" and constitutes "a final adjudication of the property rights of the parties" to the divorce action. *Shoosmith v. Scott, 217 Va. 290, 292, 227 S.E.2d 729, 731 (1976)*. Thus, the right of the children to the benefits of Mr. Griffin's 401(k) Salaried Savings Plan vested when the parties agreed to "name the children of the **[**589]** marriage as co-beneficiaries **[***42]** under all 401(k) plans and other such plans which would be distributed upon the death of either party." The QDRO is simply an administrative mechanism to enforce these rights that accrue under state law, and federal law has *not* overridden this mechanism by determining that the benefits of a plan excepted from *29 U.S.C. § 1055* vest in the surviving spouse at the participant's death. Thus, the benefit of the Commonwealth's law has not been pre-empted here.

III. CONCLUSION

Mrs. Griffin's proposed QDRO meets the specific requirements of *29 U.S.C. § 1056(d)(3)*. The Salaried Savings Plan escapes application of *29 U.S.C. § 1055*, and the benefits did not vest in Cowser-Griffin at Mr. Griffin's death. Therefore, we reverse and remand with direction to the circuit court to enter the proposed QDRO.

Reversed and remanded.

Dissent by: Huff

Dissent

Huff, J., dissenting,

I respectfully dissent because the Salaried Savings Plan is, as the majority concluded, governed by ERISA, which pre-empts state law. *Boggs v. Boggs, 520 U.S. 833, 841, 117 S. Ct. 1754, 138 L. Ed. 2d 45 (1997)* ("ERISA's express pre-emption clause states that the Act 'shall supersede any and all State laws insofar as they may now or hereafter relate to any **[*767]** employee benefit plan . . . .' [*29 U.S.C.] § 1144(a)*.").[8] **[***43]** I depart from the analysis of the majority in their conclusion that the "Dominion Salaried Savings Plan is . . . excepted by the statutory language" of *29 U.S.C. § 1055(b)(1)(C)(i)*, and is therefore alienable under state law. As suggested by its title, the exception provision of *§ 1055* relates to retirement plan annuities. The statutory language governing annuities is excepted when "the participant's nonforfeitable accrued benefit . . . is payable *in full*, on the death of the participant *to the participant's surviving spouse*." *29 U.S.C. § 1055(b)(1)(C)(i)* (emphasis added). Moreover, the concession made by Mr. Griffin's estate was not that the Salaried Savings Plan was exempt from the federal act and therefore was alienable under state law. Rather, Mr. Griffin's estate was asserting that since the benefit is payable to the surviving spouse, in a lump sum, the statutory safeguards relating to annuities are not applicable and the surviving spouse is protected in the absence of a QDRO or spousal consent.[9] Being excepted from *§ 1055* does not mean that the benefit is exempted from the policy or **[*768]** provisions of ERISA. *Boggs, 520 U.S. at 843*.

Mr. Griffin was employed by Dominion Virginia Power at the time of his divorce and until his death on May 26, 2012. Griffin was obligated, by the terms of the Griffin DRO, to name his two children as co-beneficiaries under any 401(k) and other similar plans. As part of his employment benefits, he participated in a pension plan, the Dominion Power Pension Plan, and a 401(k) type of plan, the Dominion Salaried Savings Plan. Griffin, however, did not comply with the terms of the Griffin DRO by naming his children as co-beneficiaries of any retirement benefits. Rather, when he remarried after **[**590]** his divorce from appellant, he named his new wife, Kimberly Cowser-Griffin ("Cowser-Griffin"), as the primary beneficiary and named his children as contingent beneficiaries. In the trial court, appellant requested a QDRO to enforce the terms of the Griffin DRO as applied to the Dominion Salaried Savings Plan.

As an employee benefit plan, the Plan is governed by the Employee Retirement Income Security Act ("ERISA") and Dominion's plan **[***46]** documents.[10] Dominion's plan documents provide the specific payout method employed by the Plan Administrator to distribute benefits, requiring that the surviving spouse receive the funds unless written spousal consent is obtained prior to retirement or death. The Plan Administrator may deviate from this payout method only in response to a QDRO.

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[8] The majority maintains that the Boggs decision dealt **[***44]** only with an annuity benefit, but the issues in that case, like the one before us, also covered a "lump-sum distribution from the [Employer] Savings Plan for Salaried Employees . . . ." *Id. at 836*. Specifically, in analyzing the employee savings plan sums at issue, the Boggs Court noted, "While some individual account plans escape *§ 1055*'s surviving spouse annuity requirements under certain conditions, Congress still protects the interests of the surviving spouse by requiring those plans to pay the spouse the nonforfeitable accrued benefits . . . ." *Id. at 843*.

[9] Specifically, Mr. Griffin asserts:

> [E]ven excepted pension plans must specifically require the participant's benefits to be paid to the surviving spouse, absent written consent to an alternate payee . . . . [W]hether classified as a Joint and Survivor Annuity, a Preretirement Survivor Annuity, or simply paid out as benefits under a 401(k) plan such as the Dominion Salaried Savings Plan, ERISA provides that all pension plan benefits are payable to the surviving spouse upon the death of the plan participant, absent written consent of that spouse to a different election by the participant . . . . Thus, the Salaried Savings Plan **[***45]** requires distribution to a surviving spouse unless a completed, signed and notarized consent is returned to the plan administrator before the plan participant's death.

[10] All parties concede that the Plan is an employment benefit plan or "pension plan" governed by ERISA.

Fourteen years after the Griffin DRO was entered and approximately three months after Griffin's death, appellant filed a motion in the trial court seeking to reinstate the prior divorce proceedings and enter the proposed Griffin QDRO, preserving the beneficiary status for her children under the Plan. Prior to this motion, neither appellant nor her children had notified the Dominion Plan Administrator of any alleged **[*769]** interest in the benefits outlined in the Griffin DRO. Additionally, Cowser-Griffin did not provide spousal consent for any change in beneficiaries prior to Griffin's death. On May 6, 2013, the trial court denied appellant's motion, holding that the Plan's retirement benefits vested entirely in Cowser-Griffin as the designated beneficiary **[***47]** and surviving spouse under the Plan at Griffin's death.

"In determining whether the trial court made an error of law, 'we review the trial court's statutory interpretations and legal conclusions *de novo*.'" *Rollins v. Commonwealth, 37 Va. App. 73, 78-79, 554 S.E.2d 99, 102 (2001)* (quoting *Timbers v. Commonwealth, 28 Va. App. 187, 193, 503 S.E.3d 233, 236 (1998)*).

On appeal, appellant contends that the trial court erred by denying her motion for entry of a qualified domestic relations order seeking to reinstate her children's beneficiary status as required under the Griffin DRO. Specifically, she asserts that her children's rights vested when the trial court entered the Griffin DRO; thus, the entry of a posthumous QDRO would enforce rights that vested prior to Griffin's death. In support of her assertion, she argues that because ERISA stipulates no deadline for a QDRO's entry after a plan participant's death, ERISA impliedly authorizes posthumous QDROs. She also states that the entry of a posthumous QDRO would not impair the Plan's administration because the Plan benefits are distributed in a lump sum to the beneficiaries, as opposed to an annuity payment. Alternatively, she argues that **[***48]** this Court should characterize the Griffin DRO as a QDRO and enter it *nunc pro tunc* to the date of the trial court's entry of the Griffin DRO. Cowser-Griffin intervened on behalf of the Estate of David Griffin and argues that her rights to the benefits vested upon Griffin's death because she was the surviving spouse and did not consent to any assignment of benefits. Accordingly, she asserts that the entry of a posthumous QDRO would divest her right as the surviving spouse. She also argues that this Court should not consider the Griffin DRO to be a QDRO and enter it *nunc pro tunc* because of its failure to conform to statutory requirements.

[*770] ERISA's purpose is "to ensure the proper administration of pension and welfare plans, both during the years of the employee's active service and in his or her retirement years." *Boggs, 520 U.S. at 839*. To effectuate this administration, ERISA implemented a preemption mandate, "supersed[ing] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" governed by ERISA. *29 U.S.C. § 1144(a) (2006)*. Although ERISA requires that "benefits provided under the plan may not be assigned or alienated," *29 U.S.C. § 1056(d)(1)*, **[***49]** the Retirement Equity Act of 1984 ("REA"), Pub. L. 98-397, 98 Stat. 1426, amended ERISA to allow designation of a beneficiary other than the surviving spouse in two narrow circumstances: first, pursuant to a QDRO, *29 U.S.C. § 1056(d)(3)(A)*, and second, through spousal consent, *29 U.S.C. § 1055(c)(2)(A)*.

[591]** A DRO is defined as "any judgment, decree, or order (including approval of property settlement agreement) which . . . relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant." *29 U.S.C. § 1056(d)(3)(B)(ii)(I)*. Conversely, a DRO is deemed to be a "qualified" DRO when it "creates or recognizes the existence of an alternate payee's rights to, or assigns to an alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under a plan," and it meets certain substantive

and specificity requirements. *29 U.S.C. § 1056(d)(3)(B)(i)*. It is the responsibility of the Plan Administrator "after receipt of [a DRO], . . . [to] determine whether such order is a qualified domestic relations order and notify the participant and each alternate payee of such **[***50]** determination." *29 U.S.C. § 1056(d)(3)(G)(i)(II)*.[11] A QDRO must meet the following substantive requirements:

> (i) does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan,
>
> **[*771]** (ii) does not require the plan to provide increased benefits (determined on the basis of actuarial value), and
>
> (iii) does not require the payment of benefits to an alternate payee which are required to be paid to another alternate payee under another order previously determined to be a qualified domestic relations order.

29 U.S.C. § 1056(d)(3)(D)(i)-(iii). Moreover, a QDRO must clearly specify:

> (i) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate payee covered by the order,
>
> (ii) the amount or percentage of the participant's benefits to be paid by the plan to each such alternate payee, or the manner in which such amount or percentage is to be determined.
>
> (iii) the number of payments or period to which such order applies, and
>
> (iv) each plan to which such order applies.

29 U.S.C. § 1056(d)(3)(C)(i)-(iv).

In addition to allowing assignments of benefits pursuant to a QDRO, the REA further "enlarged ERISA's protection of surviving spouses" under *§ 1055*, *Boggs, 520 U.S. at 843*, by requiring that before a plan participant could designate a beneficiary other than his or her spouse, the spouse had to provide written consent, *29 U.S.C. § 1055(c)(2)(A)(i)-(iii)*.[12] *Section 1055* applies to all individual account plans unless the plan can meet certain requirements for exemption. *Boggs, 520 U.S. at 841* ("Congress' concern for surviving spouses is also evident from the expansive coverage of *§ 1055*, as amended by REA . . . [which] appl[ies] to all 'individual account plans' and 'defined **[*772]** benefit plans.' The terms are defined, for *§ 1055* purposes, so that all pensions plans fall within those two categories."). Individual account plans are exempt from *§ 1055* if "such plan[s] provide[] that participant's nonforfeitable accrued benefit . . . is payable in full, on the death of the participant, to the participant's surviving spouse (or, if there is no surviving spouse or the *surviving spouse consents in the manner required under subsection (c)(2) of this* section, to a designated **[***52]** beneficiary)." *29 U.S.C. § 1055(b)(1)(C)(i)* (emphasis added).[13] In other words, if spousal consent is not properly obtained, the individual account plan fails to meet the exemption's requirements, and accordingly, falls within *§ 1055*'s **[**592]** expansive coverage over individual account plans. In accordance with these guidelines, the plan documents in this case require that

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[11] Additionally, *§ 1056(d)(3)(H)(i)* states that a DRO may be determined a QDRO by "a court of **[***51]** competent jurisdiction."

[12] A spouse properly waives his or her surviving spouse beneficiary designation *only when* "the spouse of the participant consents in writing to such election, such election designates a beneficiary (or form of benefits) which may not be changed without spousal consent . . . , and the spouse's consent acknowledges the effect of such election and is witnessed by a plan representative or a notary public." Id.

[13] The majority suggests that the Plan meets this exception requirement of *§ 1055* as an individual account plan because the Plan distributes via a lump sum rather than an annuity payment. *Subsection 1055(b)(1)(C)(i)*, however, requires not only a lump sum payout, but also specifically **[***53]** requires spousal consent to designate a non-spouse beneficiary.

the surviving spouse receives the distribution unless spousal consent to a change in the beneficiary designation is obtained prior to death.[14]

The central inquiry in this case is whether the beneficiary rights to the Plan vested at the trial court's entry of the Griffin DRO or when the benefits became payable upon Griffin's death. Indeed, vesting is the threshold question to whether a posthumous QDRO would be appropriate in this **[*773]** case because if in fact Cowser-Griffin's rights vested at Griffin's death, then a posthumous QDRO would divest her of the benefits to **[***54]** which she was entitled. Although the vesting point of surviving spouse's benefits under ERISA is a case of first impression for this Court, this Court should follow the long line of precedent, including the Fourth Circuit and ERISA's own provisions, which provide that a surviving spouse's benefits are vested at the time of the participant's death. *29 U.S.C. § 1055(c)(1)(A)(i)*, *(7)(B)*; *Hopkins v. AT&T Global Info. Solutions Co., 105 F.3d 153, 156-57 (4th Cir. 1997)*.[15]

This issue pits Virginia law against ERISA's guidelines. Under Virginia law, rights vest at the entry of the final divorce decree; while under ERISA, rights vest at the plan participant's retirement or death. Compare *Himes v. Himes, 12 Va. App. 966, 970, 407 S.E.2d 694, 697, 8 Va. Law Rep. 303 (1991)* (holding that it is well established that "property rights and interests [become] vested in the parties when **[***55]** they [agree] upon them, set them forth in a valid separation agreement, and [have] them incorporated into their final divorce decree"), with *29 U.S.C. § 1055(c)(1)(A)(i)*, *(7)(B)* (requiring that a plan participant can only change beneficiary designations via spousal consent during the period between when the participant attains age 35 and when the participant dies); *Hopkins, 105 F.3d at 156-57* (interpreting *§ 1055* and concluding that the limited time period to change beneficiaries under ERISA permanently set the vesting date at either the retirement or death of the plan participant), and *29 U.S.C. § 1056(d)(1)* and *(d)(3)* (prohibiting alienation of benefits except through a QDRO). Notably, appellant recognizes this fundamental dichotomy between Virginia law and ERISA by stating that "the facts in the present case and the plan's requirement to pay benefits upon the participant's death to the surviving spouse create a clear contest between the rights created in the state court versus **[*774]** the rights granted under the [P]lan." Indeed, appellant's argument hinges on the conclusion that "[b]ecause the children's rights in the retirement plan vested well before Mrs. Cowser-Griffin had any arguable **[***56]** claim to the plan, this case should be decided in favor of the children." In my view, no convincing argument has been provided as to why this Court should apply Virginia's vesting rule when faced with ERISA's contrary vesting rule and its preemption mandate requiring invalidation of any conflicting state law. *29 U.S.C. § 1144(a)*. Importantly, the Supreme Court of Virginia has recognized that "ERISA preempts enforcement of any state law or contractual provision that 'relates to' an ERISA employee benefit plan and conflicts with an

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[14] Under the subheading "Death Benefits," the plan documents stipulate,

> Federal law requires that, *if you are married when you die*, your spouse must receive the distribution unless she or he approved your choice of another (or an additional) beneficiary before your death. Your spouse must agree to your choice of that beneficiary by signing the spousal consent portion of a Beneficiary Authorization form obtained from ACS. The form must have been completed, signed, notarized, and returned to ACS before your death.

(Emphasis in original). Additionally, the plan documents only permit the Plan Administrator to pay distributions deviating from this designation "in response to a Qualified Domestic Relations Order."

[15] Hopkins was followed in an unreported Virginia circuit court decision, holding that the surviving spouse's rights vested at the plan participant's death and that these rights could not be divested by the competing claim of an ex-wife's through a prior DRO. *Riley v. Riley, No. 132690, 1998 Va. Cir. LEXIS 409, 1998 WL 972328, at *3-5 (Va. Cir. Ct. Aug. 14, 1998)*.

ERISA provision." *Brown v. Brown by Beacham, 244 Va. 319, 325, [**593] 422 S.E.2d 375, 379, 9 Va. Law Rep. 279 (1992)* (finding that ERISA allowed a notarized signature to constitute spousal consent).

In Boggs, the United States Supreme Court recognized that ERISA may at times conflict with jurisprudence typically reserved to the states, but nevertheless, insofar as such state law conflicts with ERISA, the federal law prevails. *Boggs, 520 U.S. at 841* ("We can begin, and in this case end, the analysis by simply asking if state law conflicts with the provisions of ERISA or operates to frustrate its objects. We hold that there is a conflict, which suffices to resolve the case."). Although **[***57]** the United States Supreme Court recognized the historic "central" role of state courts in regulating domestic relations matters, *id. at 840*, the Court by no means granted state courts exclusivity, but rather, invalidated the state court's law simply on the basis of its conflict with ERISA, *id. at 841*. ERISA attempts to promote the efficient distribution of benefits and protect the interests and rights of participants and beneficiaries. Cf. *Boggs, 520 U.S. at 844-46*. If ERISA could not preempt state law, then "states [would be] free to change ERISA's structure and balance," and the goals of ERISA would be thwarted. Id.

Neither federal nor state law supports the entry of a posthumous QDRO to divest a surviving spouse's vested rights **[*775]** to benefits.[16] Rather, the direct opposite assertion—that a surviving spouse's vested rights may not be divested by a posthumous QDRO—finds support in both federal and state law.

The Fourth Circuit considered the question of vesting in Hopkins, holding that a surviving spouse's rights vested at the plan participant's retirement and could not be divested by a post-retirement QDRO. *105 F.3d at 157*. In the only reported Virginia case to deal with this issue, a Virginia circuit court applied Hopkins' rationale, held that a surviving spouse's rights vested at the plan participant's death, and refused to divest the surviving spouse's vested rights in favor of an ex-wife's alleged rights under a DRO. *Riley v. Riley, No. 132690, 1998 Va. Cir. LEXIS 409, 1998 WL 972328, at *3-5 (Va. Cir. Ct. Aug. 14, 1998)*. Other federal circuits and state courts have followed this same line of analysis, refusing to divest the vested rights of a surviving spouse when faced with a post-retirement or posthumous QDRO and the plan had no notice of the proposed QDRO before the participant's death or retirement. E.g., *Carmona v. Carmona, 544 F.3d 988, 993 (9th Cir. 2008)* ("[A] state DRO may not create an enforceable **[***59]** interest in surviving spouse benefits to an alternate payee after a participant's retirement, because ordinarily at retirement the surviving spouse's interest irrevocably vests."); *Rivers v. Cent. & S.W. Corp., 186 F.3d 681, 683-84 (5th Cir. 1999)* ("[T]he benefits irrevocably vested in the second wife on the date of her husband's retirement, and plaintiff's failure to obtain a qualified domestic relations order . . . prior to her ex-husband's retirement forever barred her from acquiring any interest in the plan."); *Langston v. Wilson McShane Corp., 828 N.W.2d 109, 116 (Minn. 2013)* ("We find the reasoning of the Carmona and Hopkins courts to be persuasive and adopt the rule that **[*776]** surviving spouse benefits generally vest under ERISA at the time of the plan participant's retirement.").[17]

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[16] Although *29 C.F.R. 2530.206(c)(2)* provides examples for when a posthumous QDRO may be entered after the plan participant's death, none of the examples involve a competing vested claim to the benefits. Indeed, the examples include no situation in which there is a competing claim to **[***58]** the benefits. Accordingly, these examples do not address the crucial threshold question in this case of vesting and provide no basis for allowing alienation of a benefit vested in the surviving spouse.

[17] See also *Singleton v. Singleton, 290 F. Supp. 2d 767, 772 (W.D. Ky. 2003)* (refusing to divest a current spouse's rights when the plan participant retired because "[t]he requirements for disenfranchising a current spouse are strictly applied for good and valid reasons"); *Stahl v. Exxon Corp., 212 F. Supp. 2d 657, 669-70 (S.D. Tex. 2002)* (citing the majority of circuits that a surviving spouse's rights vest **[***60]** upon the plan participant's death and refusing to divest the surviving spouse's rights through a posthumous QDRO).

Here, appellant waited fourteen years to seek a QDRO and at no point did she provide the Plan Administrator with any notice of a **[**594]** competing claim to the benefits.[18] Under ERISA, Cowser-Griffin's rights to the Plan benefits vested at Griffin's death. Accordingly, the vested rights of Cowser-Griffin cannot be divested through a posthumous QDRO.

Similarly, the vesting issue cannot be dodged by finding that the Griffin DRO was a QDRO and entering it *nunc pro tunc* to an earlier date before **[***61]** Griffin's death.[19] The majority has correctly observed that the DRO lacked the requisite specificity to be deemed a QDRO. This Court cannot consider the **[*777]** Griffin DRO to be a QDRO because the Griffin DRO fails the specificity requirements of a QDRO because it does not list the percentage distribution of benefits between the children, the number of payments, or each plan to which it applies. *29 U.S.C. § 1056(d)(3)(C)*. Strict compliance with the substantive and specificity requirements is required in order for a DRO to qualify as a QDRO, regardless of whether these deviations may result in inequitable results. *Hawkins v. C.I.R., 86 F.3d 982, 992 (10th Cir. 1996)* (holding that "to accept anything less than what [the specificity requirements mandate] would contravene the Supreme Court's frequent admonition that courts must not read language out of a statute").

A DRO may be qualified only when it clearly specifies the plans to which it applies and the amounts and timing of the payments to be received by each beneficiary. See *Metro. Life Ins. Co. v. Bigelow, 283 F.3d 436 (2d Cir. 2002)* (finding that a DRO could be qualified when it clearly specified each plan to which it applied by identifying the plan as the "General Electric insurance plan which consists of group life insurance, disability death and insurance"); *Stewart v. Thorpe Holding Co. Profit Sharing Plan, 207 F.3d 1143, 1152 (9th Cir. 2000)* (finding that a DRO could be qualified when it specified that the beneficiary was "to receive 'one-half of the community interest'" in the plan); *Metro. Life Ins. Co. v. Marsh, 119 F.3d 415, 422 (6th Cir. 1997)* (finding that DRO could be **[***63]** qualified because it stipulated the percentage distribution to the beneficiaries as two-thirds of the plan). Courts require that the specificity requirements be met with particularity. See *Hamilton v. Wash. State Plumbing & Pipefitting Indus. Pension Plan, 433 F.3d 1091, 1096-97 (9th Cir. 2006)* (finding that a DRO failed the specificity requirements for a QDRO because it "does not require any action by the Plans, does not assign death benefits to the Children, and does not specify when the payments begin or the amount, calculation, or form of the payments");[20] *Bd. of Trs. of Plumbers & Pipefitters **[*778]** Nat'l Pension Fund v. Saxon, 470*

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[18] The Dominion Plan Administrator has already rejected the proposed Griffin QDRO on the grounds that it would "requir[e] payment of a portion of the surviving spouse's survivor benefits to another person," thus violating the substantive requirements of a QDRO which provide that the QDRO cannot pay benefits not otherwise available under the Plan. Indeed, if the trial court were to enter the proposed Griffin QDRO, the parties would be faced with the Plan Administrator's standing decision to reject the proposed Griffin QDRO and would need to seek review the Plan Administrator's decision for error.

[19] The trial court could not enter the proposed Griffin QDRO *nunc pro tunc* (as opposed to the Griffin DRO) because this action would implicate the threshold question of vesting discussed supra. As appellee correctly points out, the exclusion of the posthumous QDRO is not simply a matter of timing, but is contingent on the issue of vesting. **[***62]** Accordingly, appellant's only remaining remedy would be for this Court to determine the Griffin DRO to be a QDRO.

I respectfully disagree with the majority's suggestion that we need to determine whether the proposed QDRO meets the statutory requirements. The issue is whether the existing terms of the DRO satisfied the statutory requirement for a QDRO to defeat the vested surviving spouse's claim to the benefits.

[20] The Ninth Circuit additionally held that besides specificity, in order for a QDRO to divest a surviving spouse of her rights, the proposed QDRO had to assign rights to a former spouse, rather than to children. *Id. at 1104*. This specific approach has not been adopted in the Fourth Circuit nor in Virginia **[***64]** courts, and is an unnecessary complication of the specificity requirements and interpretation of *§*

F. Supp. 2d 605, 609 n.5 (E.D. Va.) (finding that a DRO requiring a husband to "keep the Wife listed as a beneficiary on the plan" was "extremely **[**595]** vague" and could not be considered a QDRO), aff'd in part, vacated in part, *251 Fed. Appx. 155 (4th Cir. 2007)*.

The Griffin DRO fails the specificity requirements because it does not list the amount to be paid to the beneficiaries, the number of payments or durational period, nor the specific plans to which it applies. Rather, the Griffin DRO is an amorphous requirement that the parties agree to "name the children of the marriage as co-beneficiaries under all 401K plans and other such plans which would be distributed upon the death of either party." The lack of specificity is fatal to the Griffin DRO. This Court cannot relax the specificity requirements because to do so would defy Congress's clear requirement that a DRO becomes qualified "*only if* such order clearly specifies" certain requirements. *29 U.S.C. § 1056(d)(3)(C)*. Indeed, the specificity requirements were enacted to protect the Plan Administrator's ability to efficiently distribute plan benefits. *Hawkins, 86 F.3d at 992-93*. The Griffin DRO provides no such ease of distribution because **[***65]** it fails to include the amount payable to each child, when the money is to be paid, nor even the specific plans it applies to.

In this case state law conflicts with the provisions of ERISA. The federal protection afforded to the surviving spouse should prevail because neither a QDRO nor spousal consent have been established.

For the foregoing reasons, I respectfully dissent.

End of Document

1056(d)(3)(C)(i)-(iv). This Court need not reach this rationale because the Griffin DRO is not valid as a QDRO because it fails the specificity requirements.

- Payments from sections 25-239, 25-240, and 25-241 of the Code of Virginia for relocation assistance.

- Payments from sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973.

- Retroactive Supplemental Security Income and/or retroactive Social Security payments for nine (9) months after the month of receipt of the payment(s).

- Retained disaster assistance.

M1450.400 TRANSFERS THAT DO NOT AFFECT ELIGIBILITY

A. Policy

An asset transfer does NOT affect eligibility for Medicaid payment of LTC services if the transfer meets the following criteria:

- the transfer(s) of assets was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services (M1450.400 B),

- the individual received adequate compensation for the asset(s), or

- the asset transfer meets the criteria in either section B, C or D below.

If the transfer **does not** meet the criteria in this section, see section 1450.500 below to evaluate the asset transfer.

B. Reason Exclusive of Becoming or Remaining Medicaid Eligible

Assume that when an institutionalized individual or his community spouse has transferred assets for less than the CMV during the look back period, the transfer is subject to a penalty period. During this penalty period, Medicaid will not pay for LTC services. The institutionalized individual must be given the opportunity to rebut this assumption by showing satisfactorily that he intended to receive CMV or that the reason for the transfer of assets was exclusively for a purpose other than to qualify for Medicaid.

The individual must provide convincing and objective evidence showing that there *was* no reason to believe that Medicaid payment of LTC services might be needed. *The fact the individual had not yet applied for Medicaid, had not been admitted to an institution or was not aware of the asset transfer* provisions *does not meet the evidence requirement*. The sudden loss of income or assets, the sudden onset of a disabling condition or personal injury may provide convincing evidence.

The individual must provide evidence that other assets were available at the time of transfer to meet current and expected needs of that individual, including the cost of nursing home or other medical institutional care.

C. **Home Property Transferred to Certain Individuals**

Transfer of the individual's home, whether it was excluded or not excluded at the time of transfer, does NOT affect eligibility for LTC services' payment when the home property is transferred to one or more of the individuals listed below.

1. Spouse, Minor Child, Disabled/Blind Child

The transfer of the home property does not affect eligibility when transferred to the individual's

- spouse,
- child(ren) under age 21 years, or
- child(ren) of any age who is blind or disabled as defined by SSI or Medicaid.

2. Sibling

The transfer of the home property does not affect eligibility when transferred to the individual's sibling or half-sibling (not step-sibling) who:

- has an equity interest in the home, and
- who resided in the individual's home for at least one year immediately before the date the individual became an institutionalized individual.

3. Adult Child

The transfer of the home property does not affect eligibility when transferred to the individual's son or daughter (not including step-child) who resided in the home for at least two years immediately before the date the individual became an institutionalized individual, and *all of* the criteria listed in items a. through d. below *are met.*

a. Provided Care for 2 Years

The individual's son or daughter must have been providing care to the individual during the entire two-year period which permitted the individual to reside at home rather than in a medical institution or nursing facility.

b. Physician's Statement

The individual or his/her representative must provide a statement from his/her treating physician which states

- the individual's physical and/or mental condition during this two-year period,
- why the individual needed personal and/or home health care during this period, and
- the specific personal/home health care service needs of the individual.

c. Statement of Services Provided

The son or daughter must provide a statement showing:

1) the specific services and care he/she provided to the individual during the entire two years;
2) how many hours per day he/she provided the service or care;

3) whether he/she worked outside the home or worked from the home during this period; how the individual's needs were taken care of while he/she worked; and

4) if the son or daughter paid someone to actually give the care to the individual, who was paid, the rate of pay, the specific services, and the length of time the services were provided.

d. Third Party Statement

The individual or his/her representative must provide an objective statement from a third party(ies) who had knowledge of the individual's condition and his/her living and care arrangements during this period which corroborates the son or daughter's statement. The statement must specify the care/services the son or daughter provided and who cared for the individual when the son or daughter was not at home.

***D.* Transfer to Certain Individuals or Trusts**

Transfer of any asset

- to the individual's spouse or to another person for the sole benefit of the individual's spouse;
- to another individual by the spouse for the sole benefit of the spouse;
- to the individual's child under 21 or child of any age who is blind or disabled as defined by SSI or Medicaid;
- to a trust that is established solely for the benefit of the individual's
  1) child under age 21, or
  2) child of any age who is blind or disabled as defined by SSI or Medicaid when the trust meets the conditions in M1120.202;
- to a trust established solely for the benefit of an individual under 65 who is disabled as defined by SSI or Medicaid, when the trust meets the conditions in M1120.202;

does not affect eligibility for Medicaid payment of LTC services.

1. For the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer is for the sole benefit of a spouse, blind or disabled child or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child or a disabled individual can benefit from the assets transferred in any way, whether at the time of transfer or at any time in the future. Similarly, a trust is established for the sole benefit of a spouse, blind or disabled child or a disabled individual if no one but the spouse, blind or disabled child or disabled individual can benefit from the assets in the trust, whether at the time of transfer or at any time in the future.

In order to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the trust funds for the benefit of the individual that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void. Exception: trusts established for disabled individuals, as described in M1120.202.

However, the trust may provide for reasonable compensation for a trustee(s) to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

2. Not for the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is NOT the spouse, a blind or disabled child or a disabled individual, is NOT considered established for the sole benefit of one of these individuals. Thus, the establishment of such a trust is a transfer of assets that affects eligibility for Medicaid payment of LTC services.

3. Trusts for Disabled Individuals Under Which the State Is Beneficiary

Trusts established for disabled individuals, as described in M1120.202, do not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved. However, under these trusts, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the state, up to the amount of Medicaid benefits paid on the individual's behalf.

The trust does not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved when:

* the trust instrument designates the state as the recipient of funds from the trust, and

* the trust requirements in M1120.202 require that the trust be for the sole benefit of an individual.

The trust may also provide for disbursal of funds to other beneficiaries provided that the trust does not permit such disbursals until the state's claim is satisfied. "Pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary.

4. Cross-reference

If the trust is not for the sole benefit of the individual's spouse, blind or disabled child or a disabled individual, and it does not meet the criteria in item M1450.400 D.3 above, go to M1450.*550* to determine if the transfer of assets into the trust affects Medicaid payment for LTC services.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

E. Other Asset Transfers

For asset transfers other than those described in sections M1450.400 B and C, the transfer does not affect eligibility for Medicaid payment of LTC services if the individual shows that he intended to receive or received adequate compensation for the asset. To show intent to receive adequate compensation, the individual must provide objective evidence according to items 1 through 3 below, and provide evidence that the transfer was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services.

1. Evidence of Reasonable Effort to Sell

The individual must provide objective evidence for real property that he/she made an initial and continuing reasonable effort to sell the property. See M1130.140.

2. Evidence of Legally Binding Contract

The individual must provide objective evidence that he/she made a legally binding contract (as defined in M1450.003 above) that provided for his/her receipt of adequate compensation in a specified form (goods, services, money, etc.) in exchange for the transferred asset.

If the goods received include term life insurance, see M1450.510 below.

3. Irrevocable Burial Trust

The individual must provide objective evidence that the asset was transferred into an irrevocable burial trust. The trust is NOT compensation for the transferred money unless the individual provides objective evidence that all the funds in the trust will be used to pay for identifiable funeral services.

Objective evidence is the contract with the funeral home which lists funeral items and services and the price of each, when the total price of all items and services equals the amount of funds in the irrevocable burial trust.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

F. Post-Eligibility Transfers by the Community Spouse

Post-eligibility transfers of resources owned by the community spouse (institutionalized spouse has no ownership interest) do not affect the institutionalized spouse's continued eligibility for Medicaid payment of LTC services.

Exception: The purchase of annuity by the community spouse on or after February 8, 2006 may be treated as an uncompensated transfer. See G. below.

G. Purchase of an Annuity by Community Spouse

For applications made on or after July 1, 2006, an annuity purchased by the community spouse on or after February 8, 2006, will be treated as an uncompensated transfer unless:

* the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or

* the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child. If the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state must be named in the first position.

H. Transfers Made on or After February 8, 2006 with Cumulative Value Less Than or Equal to $4,000

The policy in this subsection applies to actions taken on applications, renewals or changes on or after July 1, 2006 for transfers made on or after February 8, 2006.

Asset transfers made on or after February 8, 2006 that have a total cumulative value of less than or equal to $1,000 per calendar year will not be considered a transfer for less than fair market value and no penalty period will be calculated.

Assets transferred on or after February 8, 2006, that have a total cumulative value of more than $1,000 but less than or equal to $4,000 per calendar year may not be considered a transfer for less than fair market value if documentation is provided that such transfers follow a pattern that existed for at least three years prior to applying for Medicaid payment of LTC services. Christmas gifts, birthday gifts, graduation gifts, wedding gifts, etc. meet the criteria for following a pattern that existed prior to applying for Medicaid payment of LTC services.

I. LTC Partnership Policy

The value of assets transferred that were disregarded as a result of an LTC Partnership Policy does not affect an individual's eligibility for Medicaid payment of LTC services. See M1460.160 for more information about LTC Partnership Policies.

J. Return of Asset

The transfer of an asset for less than fair market value does not affect eligibility for Medicaid LTC services' payment if the asset has been returned to the individual.

K. Home Foreclosure

The repossession and/or sale of a home by the mortgage lender for less than fair market value due to foreclosure is not evaluated as an uncompensated transfer. Documentation of the foreclosure must be retained in the case record.

L. *Court-ordered or Approved Sale*

When property is ordered to be sold at a judicial sale or when a court has approved the sale of property for less than FMV, the sale is considered a compensated transfer. The individual or guardian must provide documentation of the court order for the sale and any other documentation needed to verify the sale of the property.

***M.* Transfer of Income Tax Refund or Advance Payment Received After December 31, 2009 but Before January 1, 2013**

Under Section 728 of the Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010 (P.L. 111-312, the transfer of an income tax refund or advance payment received after December 31, 2009 but Before January 1, 2013, to another individual or to a trust does NOT affect eligibility for Medicaid payment of LTC services. If the funds are given away or placed in a trust, other than a trust established for a disabled individual (see M1120.202), after the end of the exempt period, the transfer is subject to a transfer penalty or being counted under the Medicaid trust provisions, as applicable.

M1450.500 TRANSFERS THAT AFFECT ELIGIBILITY

A. Policy

If an asset transfer does not meet the criteria in sections M1450.300 or M1450.400, the transfer will be considered to have been completed for reasons of becoming or remaining eligible for Medicaid payment of LTC services, unless evidence has been provided to the contrary.

Asset transfers that affect eligibility for Medicaid LTC services payment include, but are not limited to, transfers of the following assets:

- cash, bank accounts, savings certificates,
- stocks or bonds,
- resources **over $1,500** that are excluded under the burial fund exclusion policy,
- cash value of life insurance when the total face values of all policies owned on an individual exceed $1,500
- interests in real property, including mineral rights,
- rights to inherited real or personal property or income**.**

B. Procedures

Use the following sections to evaluate an asset transfer:

Va. Code Ann. § 20-155

Current through the 2020 Regular Session of the General Assembly

VA - Code of Virginia (Annotated) > TITLE 20. DOMESTIC RELATIONS > CHAPTER 8. PREMARITAL AGREEMENT ACT

§ 20-155. Marital agreements

Married persons may enter into agreements with each other for the purpose of settling the rights and obligations of either or both of them, to the same extent, with the same effect, and subject to the same conditions, as provided in *§§ 20-147* through *20-154* for agreements between prospective spouses, except that such marital agreements shall become effective immediately upon their execution. If the terms of such agreement are (i) contained in a court order endorsed by counsel or the parties or (ii) recorded and transcribed by a court reporter and affirmed by the parties on the record personally, the agreement is not required to be in writing and is considered to be executed. A reconciliation of the parties after the signing of a separation or property settlement agreement shall abrogate such agreement unless otherwise expressly set forth in the agreement.

History

1987, c. 41; *1998, c. 638*; *2003, cc. 662*, *669*.

End of Document

Va. Code Ann. § 20-150

Current through the 2020 Regular Session of the General Assembly

VA - Code of Virginia (Annotated) > TITLE 20. DOMESTIC RELATIONS > CHAPTER 8. PREMARITAL AGREEMENT ACT

§ 20-150. Content of agreement

Parties to a premarital agreement may contract with respect to:

1. The rights and obligations of each of the parties in any of the property of either or both of them whenever and wherever acquired or located;

2. The right to buy, sell, use, transfer, exchange, abandon, lease, consume, expend, assign, create a security interest in, mortgage, encumber, dispose of, or otherwise manage and control property;

3. The disposition of property upon separation, marital dissolution, death, or the occurrence or nonoccurrence of any other event;

4. Spousal support;

5. The making of a will, trust, or other arrangement to carry out the provisions of the agreement;

6. The ownership rights in and disposition of the death benefit from a life insurance policy;

7. The choice of law governing the construction of the agreement; and

8. Any other matter, including their personal rights and obligations, not in violation of public policy or a statute imposing a criminal penalty.

History

1985, c. 434; 1986, c. 201.

End of Document

Shenk v. Shenk

Court of Appeals of Virginia

November 19, 2002, Decided

Record No. 2723-01-3

Reporter
39 Va. App. 161 *; 571 S.E.2d 896 **; 2002 Va. App. LEXIS 680 ***

WILLIAM R. SHENK v. BRENDA C. SHENK

Prior History: [*1]** FROM THE CIRCUIT COURT OF ROCKINGHAM COUNTY. John J. McGrath, Jr., Judge.

Disposition: Affirmed.

Counsel: Argued by teleconference.

Stephen G. Cochran (William H. Ralston Jr.; Lisa L. Knight; The Ralston & Knight Law Firm, on briefs), for appellant.

David A. Penrod (Hoover, Penrod, Davenport & Crist, on brief), for appellee.

Judges: Present: Judges Annunziata, Bumgardner and Frank. OPINION BY JUDGE ROBERT P. FRANK.

Opinion by: ROBERT P. FRANK

Opinion

[*163] [897]** OPINION BY JUDGE ROBERT P. FRANK

William R. Shenk (husband) appeals from a final decree of divorce entered by the Circuit Court for Rockingham County, which included an order finding husband and Brenda C. Shenk (wife) entered into a marital agreement when they signed an "assignment." Based on this ruling, the trial court determined several businesses were the separate property of wife. Husband argues the **[**898]** "assignment" did not convert marital property into separate property and the "assignment" was unconscionable. For the reasons stated below, we affirm the trial court's ruling.

[*164] I. BACKGROUND

The parties were married in 1981. In mid-1997, husband left the marital home in Harrisonburg, Virginia, and did not return, although he stayed in town and continued **[***2]** his involvement in the family's businesses. In June 1998, husband left Virginia. He occasionally returned to visit his children, but he did not live in the Commonwealth nor did he send wife any money for child or spousal support.

When husband left Virginia, he and wife owned several businesses in Harrisonburg. [1] Shenk Enterprises, a Honda motorcycle dealership, was sold by the parties around the time husband left. The proceeds from this sale, after the debts were paid, consisted of several promissory notes totaling approximately $ 375,000, payable over eighty-four months. The parties also owned and operated the Shenandoah Heritage Farmer's Market (the Market), [2] which rented space to independent stores, and a store within the Market known as Grandma's Pantry.

Prior to their separation, the parties both worked in the Market and Grandma's Pantry. **[***3]** When the parties separated, these businesses were in financial trouble. The Market had over $ 2.2 million dollars in debt on its books and a negative cash flow. The Market's assessed value was $ 1.75 million as of March 1999. Its construction loan through Community Federal Savings Bank was in danger of foreclosure and needed to be replaced by permanent financing. Grandma's Pantry was not profitable.

Knowing the state of the businesses, husband decided unilaterally and secretly to leave Virginia in June 1998. He left a letter for wife:

For sometime now I have been a perceived liability and embarrassment to your family, my family and I feel to you. **[*165]** Because of our inability to live our lives privately, and the relentless pursuit of WBW, my high visibility in the community and the belief of you and other family around me that I am a liability to the success and health of the market. I will no longer settle for that or even a zero effect to those close to me. I will and I must for my own health be a positive force and a source of pride to those around me. I know that I have the ability to make a difference and must find out how and were [sic] that is to be. I will be leaving Harrisonburg **[***4]** and not returning . . . .

I wish for you happiness, fulfillment, contentment, and to finally have a peace about who you are. I do, and will always believe that you can do and be anything you would like or need to be if you will just visualize and believe in yourself. I believe that I have been an overwhelming shadow of intimidation for you and at the same time have not been able to be all that I can be and for that I am sorry.

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[1] The parties agree these businesses were originally marital property.

[2] The parties owned sixty percent of the Market, and husband's father owned forty percent.

You and others always thought money was my motivation YOU WERE WRONG . . . I am motivated by challenge and the stewardship of using or losing my talents . . . My greatest pain comes from the knowledge that what really matters is relationships. . . . I have always been able to develop meaningful relationships (Business and Social) with those outside your circle of influence. . . . (Lightspeed, Lemco, Racing, etc.). I feel like a hostage with Cory, Joy, and Brian, for it seems I can only have a relationship with them if it includes you "or us" and in that environment I do not feel like I am the positive example I can be for our children . . .

As for the proceeds from Shenk Honda, SHFM, Grandma's Pantry etc., I leave it all . . .

I will do what I can to answer **[***5]** questions and give direction in my absence if it is desired or needed.

[899]** (Ellipses in original). The letter then listed the proceeds of the Shenk Honda sale.

[*166] Husband left town and was never again involved with the businesses. He made no significant financial contribution to the businesses after he left town, [3] although he claimed, when he returned to town to visit his children, he did some gardening work around the Market. On one of these return visits, husband told John Bincie, the parties' accountant, that "he was leaving and that he was turning everything over to [wife]."

Wife attempted to refinance the construction loan. However, officials with Community Federal Savings Bank were concerned about the effect of the parties' divorce on their ability **[***6]** to reach the assets. Bincie testified, "They didn't want to get in the middle of a marital asset dispute, so they wanted to know that [husband] was completely out of this as far as having any access to these assets." After negotiating with the bank, Bincie understood the bank wanted the parties to sign an agreement "that would prevent any marital asset issues from coming up after they made the loan."

Steven Weaver, the attorney for the businesses, testified he prepared a document to "transfer all right, title, and interest in those various entities to [wife]." When asked by the trial court if the document was "necessarily a predicate . . . to the Mercantile loan," Weaver responded, "Not that I'm aware of." Wife testified she understood the document "just confirmed what was reality."

On March 19, 1999, husband and wife signed a document labeled an "assignment." The document said, in part:

1. [Husband] desires to withdraw as an owner of Shenandoah Heritage Farmers Market, L.L.C. (hereinafter "the Market"), Shenk and Heatwole, Inc. t/a Grandma's Pantry (hereinafter "Shenk and Heatwole"), and Shenk Enterprises, Inc. (hereinafter "Shenk Enterprises").

[*167] 2. [Husband] has agreed **[***7]** to assign all of his right, title, and interest, in the aforesaid entities to [wife], individually, and/or the Market, as hereinafter set forth,

* * * * * * *

[3] Husband claims he sent money to pay various bills and expenses. However, those debts were personal debts of husband. Additionally, wife testified she could not remember receiving any money from husband, for either the businesses or support, after June 1998.

1. [Husband] does hereby give, grant, assign and transfer unto [wife] his 50% membership interest in the Market, thereby giving [wife] a 60% ownership in the Market. . . .

2. [Husband] does hereby assign all of his right, title, and interest, both individually and as a shareholder in Shenk Enterprises to [wife]. . . .

3. [Husband] does hereby assign, transfer, and convey all of his right, title, and interest, in and to [Grandma's Pantry], to [wife]. . . . [4]

The document noted husband remained "personally liable, to the extent of his current personal liability, on any and all debts of the aforesaid entities." The "assignment" also recognized wife's agreement "to use her best efforts to continue the business operations . . . [and] **[***8]** to pay the debts, liabilities, and obligations of the aforesaid entities."

With this document, and increased rent payments from Grandma's Pantry, the loan to the Market was refinanced. The businesses made a profit, for the first time, in 1999, and were expected to improve in 2000.

Husband testified he signed the "assignment" in order to "smooth out the management, to transfer responsibility to get things where they needed to be." He explained wife was attempting to "destroy" him by destroying the Market, so he wanted to become "a totally separate entity" in the hope that "she won't try to destroy it any longer." On cross-examination, husband said he believed **[**900]** he needed to sign the "assignment" "for the Community Federal financing." He claimed he "absolutely" did not intend "to sign away any of [his] marital rights in the property."

[*168] The trial court ruled from the bench that the agreement conveyed the properties to wife, as her separate property, under "the provisions relating to marital and premarital agreements" in *Code §§ 20-147 through 20-155*. The court's order, entered on April 30, 2001, held, "The parties' Assignment of March 19, 1999 is a valid contract **[***9]** and marital agreement." The order explained the court's decision relied mainly on the 1998 letter and the 1999 "assignment." The court noted neither document included a reservation "whereby the husband suggests that these post separation transfers to his wife were anything other than complete and final." The court also found, even if the agreement was invalid, husband was estopped from challenging the "assignment." [5]

II. ANALYSIS

Husband argues the trial court (1) used the wrong burden of proof and (2) erred in finding the "assignment" was intended to convert marital property into wife's separate property. Husband further argues, even if such intent were present, the assignment is unconscionable and, therefore, unenforceable. We disagree with husband.A. Burden of Proof

First, husband claims the trial court did not require wife to prove "clearly and unambiguously" under *Kelln v. Kelln, 30 Va. App. 113, 515 S.E.2d 789 (1999)*, **[***10]** that he transferred all his rights, including his marital rights, to her. However, husband has taken the court's comments out of context.

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[4] Husband also resigned his positions as president of Shenk Enterprises and Grandma's Pantry.

[5] As we find the "assignment" constituted a valid marital agreement, we do not address this alternative ruling.

When the judge announced the decision from the bench, he noted "a curious thing" about the presumption that property is marital property, codified in *Code § 20-107.3*. He explained:

But that presumption is not applicable because whatever was conveyed here was conveyed to her after the last separation. So I don't think we have a question of something **[*169]** being presumed to be marital. But in any event I don't really think that's dispositive of my ruling, but one of you may need it in the Court of Appeals.

Clearly, the court did not ignore the burden of proof. The judge merely pointed out that the presumption that property received by a spouse is marital property no longer applies after the spouses' last separation. *See Code § 20-107.3(A)(2)*.

A trial court is presumed to apply the law correctly. *Starks v. Commonwealth, 225 Va. 48, 54, 301 S.E.2d 152, 156 (1983)*; *Twardy v. Twardy, 14 Va. App. 651, 658, 419 S.E.2d 848, 852, 8 Va. Law Rep. 3407 (1992)*. The judge's statement regarding **[***11]** presumption does not indicate the trial court applied an incorrect presumption or burden in this case. Husband has not overcome the presumption of correctness. [6]

Additionally, husband did not object to this statement or any perceived error in application of the burden of proof during the hearing. In order to preserve an issue for a ruling by this Court, the specific argument must be made to the trial court at the appropriate time, or the allegation of error will not be considered on appeal. *See Torian v. Torian, 38 Va. App. 167, 185-86, 562 S.E.2d 355, 365 (2002)*. Therefore, husband did not preserve any objection to this particular aspect of the court's ruling and may not argue error now before this Court. *See* Rule 5A:18.

B. The "Assignment"

The parties agree the businesses were marital property initially. Therefore, they **[**901]** "may become separate property **[***12]** only through a 'valid express agreement by the parties' . . . or as provided in *Code § 20-107.3(A)(3)(d)*." [7] *McDavid v. McDavid, 19 Va. App. 406, 411, 451 S.E.2d 713, 716-17 (1994)* (citing *Wagner v. Wagner, 4 Va. App. 397, 404, 358 S.E.2d 407, **[*170]** 410, 4 Va. Law Rep. 80 (1987)*; *Code § 20-155*). As subsection (A)(3)(d) does not apply to the facts of this case, the issue here is whether the parties had a valid express agreement regarding the businesses.

Wife had the burden to prove to the trial court that such an agreement existed. *See id. at 411, 451 S.E.2d at 717*. She met this burden by presenting the written "assignment" to the trial court. When a written marital agreement is presented, a court applies "the same rules of formation, validity and interpretation" used in contract law, *Smith v. Smith, 3 Va. App. 510, 513, 351 S.E.2d 593, 595, 3 Va. Law Rep. 1501 (1986)*, **[***13]** except where specified by the Code. *Compare, e.g., Code § 20-149* (premarital agreements "shall be enforceable without consideration") *with Sager v. Basham, 241 Va. 227, 229-30, 401 S.E.2d 676, 677, 7 Va. Law Rep. 1639 (1991)* (a valid contract must be supported by some slight consideration).

1. Marital Agreement under *Code § 20-155*

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[6] Even if husband were correct, the evidence in this case meets the burden of proof he asks us to apply. *See infra* B(3) (Intent).

[7] Subsection (A)(3)(d) discusses commingling of assets, which is not argued here.

On appeal, husband does not contest the fact that a contract was formed. Rather, he argues the "assignment" was not intended to convert marital property into wife's separate property. We disagree.

Husband argues the "assignment" was not signed as part of separation or divorce negotiations and, therefore, is not a marital agreement. However, marital agreements are not limited to actions taken in contemplation of divorce.

Marital agreements are permitted under *Code § 20-155*:

Married persons may enter into agreements with each other for the purpose of settling the rights and obligations of either or both of them, to the same extent, with the same effect, and subject to the same conditions, as provided in *§§ 20-147 through 20-154* for agreements between prospective **[***14]** spouses, except that such marital agreements shall become effective immediately upon their execution.

Accordingly, marital agreements may address:

1. The rights and obligations of each of the parties in any of the property of either or both of them whenever and wherever acquired or located;

[*171] 2. The right to buy, sell, use, transfer, exchange, abandon, lease, consume, expend, assign, create a security interest in, mortgage, encumber, dispose of, or otherwise manage and control property;

3. The disposition of property upon separation, marital dissolution, death, or the occurrence or nonoccurrence of any other event;

4. Spousal support;

5. The making of a will, trust, or other arrangement to carry out the provisions of the agreement;

6. The ownership rights in and disposition of the death benefit from a life insurance policy;

7. The choice of law governing the construction of the agreement; and

8. Any other matter, including their personal rights and obligations, not in violation of public policy or a statute imposing a criminal penalty.

Code § 20-150.

"Courts are not allowed to write new words into a statute plain on its face." *Flanary v. Milton, 263 Va. 20, 23, 556 S.E.2d 767, 769 (2002)*. **[***15]** Husband would have us read into *Code §§ 20-155* and *20-150* a requirement that the agreement be made specifically in contemplation of divorce. While Code

§ 20-150(3) permits agreements in that context, subsection (3) does not modify the **[**902]** entirety of the section. Subsections (1), (2), and (8) do not limit marital agreements to contracts made in contemplation of divorce. Therefore, the Code allows marital agreements made outside the context of separation and divorce. *Code § 20-155* permits these agreements generally, without restricting the context to divorce or separation proceedings, subject only to the limitations of *Code §§ 20-147 through 20-154*. *See, e.g., McDavid, 19 Va. App. at 411-12, 451 S.E.2d at 717* (finding a deed of gift, executed before the parties contemplated divorce, transferred wife's marital rights to husband under *Code § 20-155*). *Code § 20-*

150(1), (2), and (8) permit contracts that transfer "all of [husband's] right, title, and interest" in the parties' businesses to wife. Therefore, **[*172]** the "assignment" is a valid **[***16]** marital agreement under Code § 20-155.

2. "Arising from the Marital Relationship"

Husband argues the "assignment" did not address rights "arising from the marital relationship," therefore, it is not a marital agreement under Black v. Edwards, 248 Va. 90, 445 S.E.2d 107, 10 Va. Law Rep. 1477 (1994). He misinterprets this case.

Black involved a suit by third parties against the estate of decedent, for his revocation of a reciprocal will after the death of his wife, which withdrew the names of the third parties as beneficiaries of his will. Id. at 91-92, 445 S.E.2d at 108. The property interests of the decedent and his wife were not in question. Only the interests of third-party beneficiaries were at issue. The estate argued that an agreement on reciprocal wills must be in writing under Code § 20-155, and this agreement was oral. Id. at 93-94, 445 S.E.2d at 109.

The Supreme Court explained, "We do not think that the legislature intended Code § 20-155 to require that contracts between spouses be in writing, while permitting other persons to make such contracts orally. **[***17]** " Id. at 94, 445 S.E.2d at 110. The Court then held:

We are of [the] opinion that the emphasized portion of Code § 20-155 clearly limits its provisions to those contracts affecting those "rights and obligations" that arise from the marital relationship. Here, each spouse's contractual intent to benefit third parties after the death of both spouses did not affect the "rights and obligations" arising from the [decedent's and his wife's] marital relationship. Thus, we conclude that Code § 20-155 is inapplicable.

Id.

Husband claims, based on *Black*, "The parties' ownership of stock in the businesses at issue does not arise from their marital relationship; it is a fact outside the marital relationship. Thus, an agreement to adjust that ownership is not a marital agreement." However, *Black* does not hold that only marital rights, *i.e.*, the rights that develop exclusively from a **[*173]** marriage, such as spousal support and equitable distribution, are the only rights and obligations covered by Code § 20-155. *Black* simply stands for the proposition that marital agreements must **[***18]** deal with the rights and obligations between spouses, not third parties. *Id.*

The only rights we are asked to examine are the interests that arose because the parties were married. [8] Unlike *Black*, where the spouses' rights to the property were not in question, this case clearly involves the spouses' "'rights and obligations' that arise from the marital relationship." *Id.* The "assignment" was a marital contract under Code § 20-155.

3. Intent

[8] Husband has never objected to the retitling of the stock and ownership interests, his removal as president of the businesses, nor the failure to include him in the operation of the businesses.

Husband also argues the agreement did not transfer his marital property to wife as her separate property because he did not intend to transfer those interests. He bases this argument on both the language of the "assignment" and parole evidence of his intent. [9]

[*19]** **[**903]** We review the terms of an agreement *de novo*. *See* Smith, 3 Va. App. at 513, 351 S.E.2d at 595 ("We are not bound by the trial court's conclusions as to the construction of the disputed provisions.").

Virginia adheres to the "plain meaning" rule - courts examine the plain language of an agreement, going beyond the written contract only when its meaning is ambiguous. *See* Pysell v. Keck, 263 Va. 457, 460, 559 S.E.2d 677, 678-79 (2002); Douglas v. Hammett, 28 Va. App. 517, 524-25, 507 S.E.2d 98, 101 (1998); Tiffany v. Tiffany, 1 Va. App. 11, 15-16, 332 S.E.2d 796, 799 (1985). Courts shall not include or ignore words to change the plain meaning of the agreement. Southerland v. ***[*174]*** Estate of Southerland, 249 Va. 584, 590, 457 S.E.2d 375, 378 (1995).

The language of the "assignment" plainly gives wife "*all* of [husband's] *right*, *title*, and *interest*" in the businesses. (Emphasis added). The preamble of the agreement expresses husband's desire to "withdraw as an owner" in all the businesses. The contract was not intended to transfer only bare legal title, as husband suggests, but transferred **[***20]** "all" of his rights.

Husband argues marital rights were not included in "all" of the rights transferred by the agreement, because the "assignment" did not explicitly refer to those rights. He compares the language of the "assignment" to the language used in the deed of gift in *McDavid*.

In *McDavid*, the wife transferred her interest in real estate to her husband "'in his own right as his separate and equitable estate as if he were an unmarried man . . . free from the control and marital rights of his present . . . spouse.'" 19 Va. App. at 411, 451 S.E.2d at 717 (ellipses in original). The Court found this language transferred wife's marital rights in the real estate to her husband. Id. at 411-12, 451 S.E.2d at 717.

While the "assignment" does not include the phrase, "marital rights," as used in *McDavid*, it does transfer "*all right*, *title*, and *interest*" to the businesses. We must "'give effect to all of the language of a contract.'" Tiffany, 1 Va. App. at 16, 332 S.E.2d at 799 (quoting Berry v. Klinger, 225 Va. 201, 208, 300 S.E.2d 792, 796 (1983)). *See also* Winn v. Aleda Constr. Co., 227 Va. 304, 307, 315 S.E.2d 193, 195 (1984) **[***21]** ("There is a presumption that the parties have not used words aimlessly.").

"All" generally means the entirety. *See Random House Webster's College Dictionary* 34 (1997). As the trial court indicated, the "assignment" did not include a reservation of any right. Instead, the "assignment" effectively eliminated all connection between husband and the ownership and control of the businesses. To find the "assignment" transferred only **[*175]** legal title would require that we ignore its use of the word, "all," which modifies "right" and "interest." The express and specific language of the agreement transferred *all* husband's rights and interests, which logically includes his marital rights, to wife.

Even if the document was ambiguous, the context in which the agreement was reached would clarify the meaning of "all of his right, title, and interest." As the trial court found:

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[9] Neither party objected to the use of parole evidence by the trial court. In fact, both parties suggested they wanted the judge to consider evidence outside the "assignment."

[Husband] basically decided to pack it in and leave. Based on the evidence, he left this letter, and he says in the letter, I will be leaving Harrisonburg and not returning. And then as for the proceeds of the Shenk Honda or [the Market], Grandma's Pantry, et cetera, I leave it all. The clear implication that is **[***22]** I leave it all to you.

* * * * * * *

And it is inconceivable to me that if his intent was not to assign to her everything and make it her separate property that that would have been specifically set forth in either the letter he left her or in the document that he signed on March 18, [sic] 1999.

[904]** The evidence supports this factual finding by the trial court. *See, e.g.*, *Welshman v. Commonwealth, 28 Va. App. 20, 36-37, 502 S.E.2d 122, 130 (1998)* (*en banc*) (explaining a trial court determines factually whether a defendant intended to distribute cocaine and that finding "is binding on appeal unless plainly wrong").

Husband relinquished all interest in the businesses to wife in a letter. The letter clearly expressed husband's intention to permanently leave his wife, children, and the businesses. He wrote, "I wish for you happiness, fulfillment, contentment, and to finally have a peace about who you are." He indicated he felt "like a hostage" with the children. He said, "As for the proceeds [of the businesses] . . . I leave it all." The "assignment" was signed eight months after husband left town. The trial court could properly infer from this letter, **[***23]** coupled with the assignment, that husband intended to divest himself of the marital relationship and the assets of that relationship.

[*176] Although husband was actively involved in running the businesses prior to leaving, he did nothing to help wife with the businesses after he wrote the letter and left town. [10] When he relinquished his rights to the businesses, he knew they had significant debt and were in danger of foreclosure.

This Court has explained intent in the context of *Code § 20-107.3* [11] :

Where the facts clearly and unambiguously support the conclusion that one of the parties has relinquished all right and interest in marital property and has transferred **[***24]** those rights unconditionally to the other, to the exclusion of the donor's continuing claim upon the property as a marital asset pursuant to *Code § 20-107.3*, a separate property right will be found to exist.

Kelln, 30 Va. App. at 122-23, 515 S.E.2d at 793-94 (discussing interspousal gifts).

Husband transferred all his right and interest in the businesses, without reservation, both in the letter and in the "assignment." He made no continuing claims on the property and exercised no control, at least until the parties began discussing a property settlement and husband discovered the businesses were beginning to make a profit, nine months after the "assignment" was executed.

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[10] Husband testified he sent money for business debts and helped with some maintenance at the Market. However, wife testified he did nothing to help. This evidence must be viewed in the light most favorable to wife, the party prevailing below. *See* *Gilman v. Gilman, 32 Va. App. 104, 115, 526 S.E.2d 763, 768 (2000)*.

[11] *Code § 20-107.3* discusses determinations of separate and marital property in the context of equitable distribution.

From the evidence, the trial court could conclude husband abandoned his family and his businesses, at a time when the businesses had no value. Indeed, **[***25]** the businesses had a negative cash flow, foreclosure was imminent, and the debts exceeded the value of the businesses. Only through the work of wife and her father-in-law did the businesses become profitable. Now, husband appears to claim the benefit of his wife's **[*177]** and father's labors. We find the businesses became wife's separate property when the parties entered into the marital agreement.

C. Unconscionability

Husband argues, if the "assignment" converted marital property to wife's separate property, then it is unconscionable under *Code § 20-151(A)(2)*. He contends (1) no consideration was exchanged, (2) husband's responsibility for the business debts continued, and (3) wife's receipt of 100% of the marital assets is facially unconscionable. We note initially that he must prove unconscionability by "clear and convincing evidence," with the evidence viewed in the light most favorable to wife, the party prevailing below. *Derby v. Derby, 8 Va. App. 19, 26, 378 S.E.2d 74, 77, 5 Va. Law Rep. 2059 (1989)*.

1. Consideration

Husband concedes a marital agreement is enforceable without consideration. Husband **[**905]** claims, however, while an agreement might be **[***26]** enforceable, in this context, the lack of consideration makes the agreement unconscionable. We disagree.

Code § 20-149 clearly states, "Such agreements [premarital and marital agreements] shall be enforceable without consideration." An agreement cannot be both unconscionable and enforceable. While *Code § 20-151* allows courts to find some marital agreements unconscionable, lack of consideration without deception or bad faith is not a factor in making such a finding. *See, e.g.*, *Derby, 8 Va. App. at 28-33, 378 S.E.2d at 78-81*.

Husband was an "experienced businessman." He does not claim he was unaware of the condition of the businesses or of their potential for growth. On appeal, neither party suggests this case involves a failure to disclose information, trickery, or bad faith. Assuming no consideration was exchanged, the agreement is still enforceable.

[*178] 2. Continuing Debt

Husband also argues the agreement is unconscionable because "the assignment does not charge the wife with all of the businesses' debts." We disagree.

The "assignment" included the following provision: "[Husband] understands **[***27]** and acknowledges that he will remain personally liable, to *the extent of his current personal liability*, on any and all debts of the [businesses] and any guaranties or endorsements that are currently in place." (Emphasis added.) Assuming husband is correct that he remained liable on the businesses' debts, we would not find the agreement unconscionable. The courts will not second-guess the wisdom of contractual provisions. *See Rogers v. Yourshaw, 18 Va. App. 816, 820, 448 S.E.2d 884, 886, 11 Va. Law Rep. 126 (1994)*.

While potentially unwise, husband signed the agreement, which clearly included the statement that he retained some liability for current debt. He does not argue the statement was hidden or ambiguous. Additionally, husband does not suggest that he ever had to make any payments on any business, as

opposed to personal, debts. He does not argue any actual detriment from this provision. In fact, wife agreed she would "use her best efforts to continue the business operations . . . [and] to pay the debts, liabilities, and obligations" of the businesses, which reduced husband's exposure on the debts and eliminated his responsibility to work in the businesses. Retention of liability **[***28]** for his existing debts is not unconscionable in this context.

3. Facial Unconscionability

Finally, husband argues the agreement is unconscionable because it gives all of the parties' significant property to wife, leaving husband with nothing. [12] He claims *Derby* controls this case.

[*179] In *Derby*, this Court found, "The gross disparity in the *value* of the property each received under the separation agreement [was] shocking in that Sandra Derby becomes sole owner of the bulk of the parties' marital property valued at $ 260,000 . . . ." *8 Va. App. at 30, 378 S.E.2d at 80* (emphasis added). The Court also noted that the agreement included a waiver of Mr. Derby's "rights to spousal support while Sandra Derby retained hers" and that evidence proved "concealment, misrepresentation, **[***29]** and undue advantage on the part of Mrs. Derby as well as emotional weakness on the part of Mr. Derby." *Id. at 31, 378 S.E.2d at 80*. None of these factors exists in the case before us.

Husband does not allege concealment, misrepresentation, undue advantage, or emotional weakness. [13] **[***30]** He argues only that wife received all of the marital assets. However, he ignores the fact that, at the time the **[**906]** "assignment" was signed, the businesses were significantly in debt and not making a profit. The value of the real estate and building was less than the amount of the debt. Wife actually became the owner of businesses that had no value and were saddled with debt. She also took over all of husband's responsibility for operating the businesses, significantly increasing her working hours. [14] Husband had no more responsibility to improve the viability of the businesses. He was free to leave the state, travel, and seek other employment, which he did. When the parties signed the agreement, wife received all the responsibility as well as all the ownership in a failing business. We do not find such an agreement is unconscionable.

[*180] The parties entered into a marital agreement. That agreement is valid. For the reasons stated above, we affirm the trial court's ruling.

Affirmed.

End of Document

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[12] The parties did own other real estate, including the marital home, which wife retained when husband left. The status of these properties as well as the parties' personal property is not an issue before us.

[13] Under the rule of law established in *Drewry v. Drewry, 8 Va. App. 460, 472-73, 383 S.E.2d 12, 18, 6 Va. Law Rep. 94 (1989)*, and *Pelfrey v. Pelfrey, 25 Va. App. 239, 244-45, 487 S.E.2d 281, 284 (1997)*, appellant must prove both (1) a gross disparity existed in the division of assets and (2) overreaching or oppressive influences created an unfair process. Husband alleges only the first prong of this test. Wife, however, does not challenge husband's unconscionability argument on his failure to allege overreaching.

[14] Husband's father still owned part of the Market and was involved in the operation of the business.

Cooley v. Cooley

Supreme Court of Virginia

February 29, 1980

Record No. 780373

Reporter
220 Va. 749 *; 263 S.E.2d 49 **; 1980 Va. LEXIS 162 ***

Carolyn J. Cooley v. Cyrus E. Cooley, Jr.

Prior History: [*1]** Appeal from a judgment of the Circuit Court of Pittsylvania County. Hon. W. Carrington Thompson, judge presiding.

Disposition: *Reversed and remanded*.

Syllabus

Separation agreement and modifying contract enforceable because adjusting property rights and not facilitating divorce.

Counsel: *Stuart L. Craig (Carter, Craig & Bass*, on brief), for appellant.

John W. Carter (Carter and Wilson, on brief), for appellee.

Judges: I'Anson, C.J., Carrico, Harrison, Cochran, Poff and Compton, JJ.

Opinion by: PER CURIAM

Opinion

[*750] **[**50]** In this civil appeal, we consider whether a post-nuptial separation agreement and a subsequent contract modifying the agreement were void and unenforceable as facilitating separation or divorce.

Appellant Carolyn J. Cooley, the wife, instituted **[***3]** this proceeding below by motion for judgment against appellee Cyrus E. Cooley, Jr., her former husband, seeking recovery of almost $ 11,000. The action is based on the husband's alleged failure to comply with the spousal support provisions of a 1971 North Carolina separation agreement as modified by a 1972 North Carolina contract.

After a bench trial, the court below decided that the instruments in question facilitated or promoted the parties' separation or divorce and thus were void as contrary to public policy. We awarded the wife an appeal from the February 1978 judgment order entered in favor of the husband.

Married in 1958 when he was in his mid-thirties and she in her mid-forties, the parties cohabited thereafter in California, Virginia and Georgia. In 1967 they moved to North Carolina where the husband became employed by Burlington Industries. Marital difficulties subsequently arose. According to the husband's testimony, denied by the wife, "she spent about fifty percent of her time in California and the other fifty percent with me" during the period from 1968 to the separation of the parties. The husband stated, "It was not uncommon for her to go [to California] **[***4]** and stay three months at a time, because she had her family out there and left me by myself."

In 1971, when it became apparent to the parties that a separation was inevitable, the wife "insisted" that a written agreement for her support be executed to provide "some security" following the separation. The husband's North Carolina attorney prepared the agreement, and it was executed by the parties on June 16, 1971. The separation occurred on that day, or the day after, when the wife left the marital abode in North Carolina and travelled to California.

The evidence was in conflict as to the precise cause for the separation and whether or not it was to be permanent. The reason assigned by the husband was that she "wanted to live in California more than she did in the Eastern part of the United States." He testified she "deserted" him and he did not expect her to return. When asked whether he wanted her to come back, Cooley replied, "Very frankly, based on everything that occurred up to the point at which she left, I didn't see that it was possible to save our marriage." On the **[**51]** other hand, the wife blamed Cooley for what she thought was to be a temporary separation, stating, **[***5]** "He said he wanted me to go to California **[*751]** to see if he missed me and he would have me back on Christmas. . . ."

The agreement recited in an introductory paragraph:

> That whereas, the said Cyrus E. Cooley and Carolyn G. Cooley are lawfully married; and whereas, after said marriage the parties hereto lived together as man and wife, and whereas the said parties hereto are very unhappy and in consequence of the circumstances under which they are now living it is reasonably necessary to the health and happiness of both of said parties that they should live

> separate and apart; and whereas, in consequence of existing conditions it has been decided by the parties hereto that it is to the best interest of all concerned for the parties hereto to make and enter into an agreement of separation . . . .

The instrument required the husband to pay her $ 350 per month for support and required him to maintain a group medical benefits insurance policy covering her. The agreement also adjusted property rights between the parties, provided for the release of curtesy and dower, and released the husband from any other obligation to pay "support, maintenance, or alimony" in the **[***6]** future.

Following the separation, the husband proceeded to make support payments in accordance with the agreement. The wife remained in California until the Spring of 1972 when she returned to North Carolina. According to her testimony, this was an unsuccessful attempt to effect a reconciliation. When she reached the marital abode, Cooley refused to converse with her, merely saying, "You leave." He denied her return was motivated by a desire to reconcile; he stated she came back to obtain some personal belongings and to pick up his daughter by a previous marriage who was "just getting out of school." After a brief period of time, the wife went back to California accompanied by the daughter.

On June 27, 1972, the husband filed suit in North Carolina for an absolute divorce against the wife upon the ground that the parties had lived separate and apart for one year. The divorce papers were served on the wife only in California and she made no appearance in the North Carolina court. She consulted California counsel who contacted Cooley's North Carolina attorney seeking an increase in spousal support. Over five months of negotiations ensued, the husband wanting a final uncontested **[***7]** divorce and the wife desiring an agreement which would adequately provide for her future support and maintenance. Finally, the parties executed a contract dated December 15, 1972 **[*752]** modifying the separation agreement and, *inter alia*, providing for an increase in the wife's monthly support. Among the prefatory statements in the writing was the following:

> WHEREAS, Carolyn J. Cooley hereby agrees that Cyrus E. Cooley, Jr. may secure a divorce without contest by Carolyn J. Cooley, in consideration for the modification of the original separation agreement, as herein provided.

Four days later, the North Carolina court entered a decree dissolving the marriage on the ground that the parties had lived continuously separate and apart since June 16, 1971.

The husband, who had remarried in 1973, left the employ of Burlington Industries in 1975 and moved to Virginia where he went to work for Dan River Mills, Incorporated. He stopped making the agreed support payments in December of 1975. The present action was filed in July of 1977 seeking judgment for arrearages allegedly due for support and medical expenses through June 15, 1977.

Because it is the policy of **[***8]** the law to foster marriage and to prevent separation, an agreement between husband and wife is void when its general purpose or specific object is to encourage or facilitate separation or divorce. *Shelton v. Stewart, 193 Va. 162, 165, 67 S.E.2d 841, 843 (1951)*; *Cumming v. Cumming, 127 Va. 16, 25, 30, 102 S.E. 572, 574, 576 (1920)*. *See Capps v. **[**52]** Capps, 216 Va. 378, 380, 219 S.E.2d 901, 903 (1975)*. But marital property settlements entered into by competent parties upon valid consideration for lawful purposes are favored in the law and such will be enforced unless their illegality is clear and certain. *Wallihan v. Hughes, 196 Va. 117, 125, 82 S.E.2d 553, 558 (1954)*. Consequently, agreements between spouses dealing with a division of property, even though in contemplation of divorce, are valid unless part of a scheme to effect a separation or to obtain a divorce by collusion. *Ryan v. Griffin, 199 Va. 891, 896, 103 S.E.2d 240, 244 (1958)*.

We reject the husband's contention that the two instruments here are void as violative of public policy. As to the 1971 agreement, the parties had experienced marital difficulties for nearly three **[***9]** years before its execution. Because of the discord, the husband and wife recognized that a separation was unavoidable. Indeed, the preamble of the agreement, drafted by the husband's attorney, recited the "unhappy" conditions and the necessity to separate for "the health and happiness of both" parties. The agreement was merely an attempt by the estranged couple to adjust mutual rights and obligations preliminary to the actual **[*753]** separation which took place immediately; the instrument was not part of a device or scheme to promote a divorce nor was its general purpose or specific object to facilitate a separation.

As to the 1972 contract, the enmity had existed unabated for an 18-month period following the June 1971 separation. Actually, the discord had been intensified by the wife's efforts to exact increased support payments and other monies from the husband. During the prolonged negotiations following institution of the divorce action, there was no dispute that the parties had been separated for one year and that the husband had valid grounds for an absolute divorce. The quarrel at that time was simply over money and was fueled by his desire for an uncontested divorce. **[***10]** The prefatory clause, *supra*, heavily relied on by the husband to support his contention that the contract was void, principally related to the promise of the wife not to contest the issue of spousal support in the divorce court in consideration for the modification of the original agreement. According to the evidence, she had no defense to the one-year separation charge; the ground for the divorce pre-existed the contract and had already become irrevocably fixed. Consequently, the general purpose of the contract, like the agreement, was to adjust the property rights; facilitation of the divorce was not its specific object. [*]

For these reasons, we conclude that the trial court erred **[***11]** in deciding the separation agreement and the contract were void. Accordingly, the judgment below will be reversed and the case remanded for a new trial limited to the issue of damages only.

Reversed and remanded.

End of Document

[*] Although mentioned in her appellate briefs, the wife did not urge during oral argument before us, nor before the trial court, according to the record, that the validity, effect and enforceability of the instruments should be governed by North Carolina law. Consequently, we have not commented on any conflict of laws issue.

ETHICAL CHALLENGES IN ELDER LAW

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"SHOWER, ANYONE?"

Hypothetical 1

You represent Norman as a beneficiary of his mother's estate. Previously unknown to virtually everyone except Norman, he has two sisters, Ivana and Marla. His mother named Ivana executor of her estate. The will is ambiguous because mom downloaded the will from the internet and added a few of her own provisions.

While none of the three siblings is incapacitated, each could be considered to have "mental disorders" of some sort and each believes that mom intended for them to get more than the other two siblings. Norman becomes particularly volatile when mom's hotel is discussed. While Norman usually only trims his fingernails with his pocket knife during your conferences, he begins waving the knife and making cutting gestures when the hotel is discussed. While neither of the sisters has specifically said they intend to seek the hotel as part of their inheritance, Norman has stated that he "would kill them" if they made such an assertion because "the hotel is mine and everybody knows it". He stated that he knows that "Mother would want me to own and run the hotel in memory of her." Attorneys for the two sisters contacted you recently with a specific offer in an attempt to settle the controversy.

1. Assuming the offer suggested selling the hotel and splitting the money in addition to splitting other estate assets, what must you tell Norman, if anything? Do previous comments from Norman have any bearing?

2. Assume you learn of the offer in question 1 just prior to a meeting with Norman wherein you learn that he suspects that Marla, who lives alone and down the street from your office, has killed his only dog and he is noticeably more agitated and upset than usual. In fact, he is enraged and states that "at least it will be good to get back to one of my old hobbies: stuffing things". Should you tell Norman about the offer in the meeting? Would it make a difference if your meeting with him was over the telephone?

3. Assume the offer would give sole ownership of the hotel to Norman, but it does not otherwise seem to be in his best interest. Do you have a duty to suggest mediation or arbitration to Norman?

Hypothetical 2

Fred and Ginger have been married for 42 years. Fred's health has recently worsened and they have come to see you to update their wills and powers of attorney. In the course of the meeting, you realize that neither has long term care insurance and they both indicate a strong preference to avail themselves of Medicaid if either needs to live in a nursing home. They wish to retain as much of their estate for the non-nursing home spouse, and eventually to pass it on to their full quiver of children and grandchildren.

You have been practicing elder law for a while and have heard a smart practitioner recommend the use of a post-nuptial agreement, primarily to as protection against an eventual augmented estate claim on the death of a community spouse once the institutionalized spouse is on Medicaid.

A. Can you draft the agreement for *both* of them?

B. Can you draft the agreement for one of them if the other retains separate counsel?

C. Would your answer differ if each had children from previous marriages? What about if one spouse was incapacitated but each had signed a power of attorney granting the spouse full gifting authority?

"DUTIFUL CHILD?"

Hypothetical 3

Lyle Melezed holds durable power of attorney for his mother, who is in need of nursing home care. In his capacity as agent for his mother, he consults with you regarding Medicaid qualification and asset preservation. Mother has about half a million in assets, but her income will not cover the private cost of her care in the nursing home. Mother's will leaves her estate in equal shares to her four children.

Only Lyle is present in the long term care consultation. He says his siblings "don't seem to care" what happens to Mother and he has to "take care of everything". He states that as the POA he is in charge and he will make the decisions. He explains that Mother "has dementia" and "would not understand any of this."

In the course of the consultation, you cover the asset preservation technique of transfer and cure, also know as "reverse half loaf". You explain that the gifting provision in the power of attorney allows Lyle to transfer Mother's assets to himself and/or his siblings. There is no requirement of equalization of gifting in the POA. You advise him that the transferred resources will create a period of ineligibility for Medicaid and that he must be prepared to pay for Mother's care during this period until the ineligibility period is cured. You further advise him that the transferred resources should be held for the benefit of Mother without her having a direct ownership interest in the assets and that once Mother passes away any remaining assets should be distributed equally between his three siblings and him, as stated in Mother's will. You advise Lyle that the best vehicle for handling the transferred funds is a special needs trust for Mother's benefit, with Lyle as the trustee and which provides at Mother's death for the distribution of the remaining funds on the same basis as in her will. You offer to prepare the special needs trust for a reasonable flat fee.

Lyle declines your offer to have you draft a special needs trust and states he intends to hold them in an account in his name only. He takes your transfer and cure calculator schedule, pays his flat fee for the long term care consultation, and leaves. You have a sinking feeling that if there is anything left once Mother passes, he intends to keep it. You also know from your conversation with Lyle that he is recently separated from his wife and contemplating divorce. He also has had some setbacks in the market and is financially shaky.

1. Who is the client?

2. What is your duty if Lyle fails to take your advice on what he should do?

3. Should you tell Lyle's siblings what he intends to do?

4. Does it matter if you have seen an original of the POA, or if Mother is incapacitated or not?

Hypothetical 4

Ronald and Melanie come to see you for estate planning. Neither was married before this marriage and they have assets sufficient to trigger federal estate taxes. The meeting goes fairly smoothly and you forget to establish your relationship with them through a representation letter. Despite that oversight, you proceed to prepare their wills, powers of attorney and advance medical directives. You are fifteen minutes from completing their A-B revocable trusts and their irrevocable life insurance trust when Ronald calls.

He explains that he was recently in a chat room and he ran into an old girlfriend who now stars in adult films. She informed him that she has raised their son, who will turn 18 in a couple of months. She was so mad at him for how he treated her that she never told him about the child. Since the child and mother sound destitute, he wants to know how he can "divert" some of his assets to "take care of" the son once he dies. "Of course, Melanie does not need to know about this youthful indiscretion," says Ronald.

1. Can you help him provide for the son?

2. Do you have a duty to tell Melanie?

3. How should you proceed?

4. Would it matter if Ronald only wanted to benefit the son if Melanie predeceases him?

"FORE! WELL, . . . MAYBE MORE?"

Hypothetical 5

You represent the beneficiary of the estate of a professional golfer who was once on track to win the most major tournaments in history. Due to the failure to settle certain claims, the estate is mired in litigation.

During a pre-trial hearing, the judge takes only the attorneys to his chambers. Opposing counsel surprises everyone by dropping photographs of people in compromising situations, allegedly of the golfer and multiple women, on the table. The photos are grainy and it is hard to tell whether they depict the golfer. The judge rules they are inadmissible and further orders the attorneys not to divulge the existence of the photos or the allegations they support with their clients. Opposing counsel is fuming and tells the other lawyers on the way back to the courtroom that a judge is not going to interfere with his client communications and says she will consider an ethics complaint against the judge.

1. Is the judge at risk for an ethical violation?

2. Is the attorney at risk for an ethical violation?

Hypothetical 6

You have represented Martha, a domestic living guru, in her capacity as executor of the estate of her late husband for the past five years. Her deceased husband's will provided for Martha and several other beneficiaries. You have learned that the other beneficiaries recently filed a lawsuit against Martha, alleging violations of securities law. She calls you and says that the beneficiaries have filed a motion to compel production of your files relating to your representation of her as executor.

Are the beneficiaries likely to succeed at the hearing on their motion to compel?

"HOW ABOUT SOME RESPECT?!"

Hypothetical 7

You represented Aretha for many years and prepared her will. She recently died and her beneficiaries have informed you they intend to initiate litigation in order to clarify the terms of the will. They indicate that they intend to seek production of your files and to elicit your testimony regarding communications you had with her in the upcoming proceedings. You tell them that you will remain neutral in the matter. You further state that you will not produce the files and that you will not testify because the attorney-client privilege survives death.

Will the heirs be able to obtain your files and elicit your testimony regarding these communications?

"SHOWER, ANYONE?"

Hypothetical 1

You represent Norman as a beneficiary of his mother's estate. Previously unknown to virtually everyone except Norman, he has two sisters, Ivana and Marla. His mother named Ivana executor of her estate. The will is ambiguous because mom downloaded the will from the internet and added a few of her own provisions.

While none of the three siblings is incapacitated, each could be considered to have "mental disorders" of some sort and each believes that mom intended for them to get more than the other two siblings. Norman becomes particularly volatile when mom's hotel is discussed. While Norman usually only trims his fingernails with his pocket knife during your conferences, he begins waving the knife and making cutting gestures when the hotel is the subject of discussion. While neither of the sisters has specifically said they intend to seek the hotel as part of their inheritance, Norman has stated that he "would kill them" if they made such an assertion because "the hotel is mine and everybody knows it". He stated that he knows that "Mother would want me to own and run the hotel in memory of her." Attorneys for the two sisters contacted you recently with a specific offer in an attempt to settle the controversy.

1. Assuming the offer suggested selling the hotel and splitting the money in addition to splitting other estate assets, what must you tell Norman, if anything? Do previous comments from Norman have any bearing?

2. Assume you learn of the offer in question 1 just prior to a meeting with Norman wherein you learn that he suspects that Marla, who lives alone and down the street from your office, has killed his only dog and he is noticeably more agitated and upset than usual. In fact, he is enraged and states that "at least it will be good to get back to one of my old hobbies: stuffing things". Should you tell Norman about the offer in the meeting? Would it make a difference if your meeting with him was over the telephone?

3. Assume the offer would give sole ownership of the hotel to Norman, but it does not otherwise seem to be in his best interest. Do you have a duty to suggest mediation or arbitration to Norman?

ANALYSIS

Rule 1.4 counsels that a lawyer shall keep a client reasonably informed, explain a matter so the client understands and inform the client of facts and communications from another party that may significantly affect resolution of the matter. Rule 1.4. Comment 5 of this Rule states that the lawyer should "promptly inform" the client of an offer of settlement in a civil case (or plea agreement in a criminal case) unless prior discussions with the client have "left it clear that the proposal will be unacceptable." Rule 1.4, Comment 5.

If Norman had previously said that under no circumstances would he agree to any offer that did not give him sole ownership of the hotel, one might think they would not have a duty to inform him of the offer. While the black letter language in Comment 5 would likely allow you to negotiate without telling Norman, prudence dictates that you inform him of the offer and seek his input. See also Rule 1.2(a).

Comment 7 to Rule 1.4 states: "In some circumstances, a lawyer may be justified in delaying transmission of information when the client would be likely to react imprudently to an immediate communication." Further, " . . . in certain limited circumstances, the attorney may not be required to fully inform the client if doing so would harm the client or cause the client to react inappropriately." NAELA Aspirational Standard H, Selected NAELA Comment C to Rule 1.4. However, a lawyer "may not withhold information to serve the lawyer's own interest or convenience". Rule 1.4, Comment 7.

While Comment 7 lists only one example ("a lawyer might withhold a psychiatric diagnosis of a client when the examining psychiatrist indicates that disclosure would harm the client"), prudence would likely dictate waiting for another time to inform Norman of his sisters' desire to sell the hotel and split the proceeds.

Rule 1.6(c)(1) states that "a lawyer shall promptly reveal . . . the intention of a client, as stated by the client, to commit a crime and the information necessary to prevent the crime, but before revealing such information, the attorney shall, where feasible, advise the client of the possible legal consequences of the action, urge the client not to commit the crime, and advise the client that the attorney must reveal the client's criminal intention unless thereupon abandoned". Might his comments only refer to his dead dog?

Comment 1 to Rule 1.4 states that the continuing duty to keep a client informed

". . . includes the duty to advise the client about the availability of dispute resolution processes that might be more appropriate to the client's goals . . . ." Rule 1.4, Comment 1. The Comment suggests that this might be particularly appropriate where a "lawyer-to-lawyer negotiation" reveals information that suggests the dispute might settle if the parties were more directly involved in the process.

Although this situation does not indicate a "lawyer-to-lawyer negotiation" yielding such information, it would likely be in Norman's best interests to suggest mediation to him.

Hypothetical 2

Fred and Ginger have been married for 42 years. Fred's health has recently worsened and they have come to see you to update their wills and powers of attorney. In the course of the meeting, you realize that neither has long term care insurance and they both indicate a strong preference to avail themselves of Medicaid if either needs to live in a nursing home. They wish to retain as much of their estate for the non-nursing home spouse, and eventually to pass it on to their full quiver of children and grandchildren.

You have been practicing elder law for a while and have heard a smart practitioner recommend the use of a post-nuptial agreement, primarily to as protection against an eventual augmented estate claim on the death of a community spouse once the institutionalized spouse is on Medicaid.

A. Can you draft the agreement for *both* of them?

B. Can you draft the agreement for one of them if the other retains separate counsel?

C. Would your answer differ if each had children from previous marriage? What about if one spouse was incapacitated but each had signed a power of attorney granting the spouse full gifting authority?

ANALYSIS

Rule 1.7 (a) states that "except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if: (1) the representation of one client will be directly adverse to another client; or (2) there is significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client . . . ." Rule 1.7(a).

Rule 1.7(b) states that "notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if each affected client consents after consultation, and: (1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client; (2) the representation is not prohibited by law; and (3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the

same litigation or other proceeding before a tribunal; and the consent from the client is memorialized in writing." Rule 1.7(b).

Whenever representing husbands and wives jointly, it is prudent to advise them that any confidences shared with you separately will need to be shared with the other spouse. "The prospective clients and the lawyer should discuss the extent to which material information imparted by either client would be shared with the other and the possibility that the lawyer would be required to withdraw if a conflict in their interests developed to the degree that the lawyer could not effectively represent each of them." ACTEC Commentaries on MRPC 1.7.

The ACTEC Commentaries provide that "[a]dvising related clients who have somewhat differing goals may be consistent with their interests and the lawyer's traditional role as the lawyer for the 'family.'" ACTEC Commentaries on MRPC 1.7. "The fact that the goals of clients are not entirely consistent does not necessarily constitute a conflict that precludes the same lawyer from representing them. Thus, the same lawyer may represent a husband and wife, or parent and child, whose dispositive plans are not entirely the same." ACTEC Commentaries on MRPC 1.6.

While the interests in this hypothetical are currently aligned, they could diverge. "What was a tolerable conflict at the outset may develop into one that precludes the lawyer from continuing to represent one or more of the clients". ACTEC Commentaries on MRPC 1.7. Perhaps the potential conflict can be disclosed and waived in writing?

One should also consider that Rule 1.1 requires that a Virginia lawyer "shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation." How many times have you prepared marital agreements? How much have you studied the articles and cases on them? Are you aware of the impact of the factor of each party having "independent counsel" on the enforceability of it? Should any of that matter in this context?

It is notable that after expressing that it would be okay in certain circumstances to represent clients whose goals are not in perfect unison, the ACTEC Commentaries further state that "[n]othing in the foregoing should be construed as approving the representation by a lawyer of both parties in the creation of any inherently adversarial contract (e.g., a marital property agreement) which is not subject to rescission by one of the parties without the consent and joinder of the other." ACTEC Commentaries on MRPC 1.6. An author for an article in the ACTEC Journal discussing *premarital* agreements concluded that "[b]ecause the potential for conflict between the parties is so great, it is very unlikely

that one lawyer can adequately represent both parties in the preparation of a premarital agreement." J. Harllee, "Using Premarital Agreements in the Estate Planning Practice", ACTEC Journal - Fall 1999.

Note that Texas Disciplinary Rule of Professional Conduct 1.06 specifically states that "[a] practitioner should *never represent both parties* when preparing a premarital *or post-marital* agreement." (emphasis added)

NAELA's Aspirational Standard C states that "[t]he blended family offers up challenges to the attorney dealing with an incapacitated person. Where the assets to be transferred for Medicaid planning would be titled in the name of a spouse who is not also the parent of the children of the incapacitated person, there may be tension as to the provisions of the well spouse's estate plan. Inquire as to the existence of a prenuptial agreement regarding such provisions and raise the issue as to the disposition of the parent's assets upon the second death. While those children would not be clients in such a scenario, there would be fallout if the parent's assets pass to the well spouse's children without that expectation having been established and agreed at the outset." NAELA Aspirational Standard C, Selected NAELA Comment D to Rule 1.2.

Hypothetical 3

Lyle Melezed holds durable power of attorney for his mother, who is in need of nursing home care. In his capacity as agent for his mother, he consults with you regarding Medicaid qualification and asset preservation. Mother has about half a million in assets, but her income will not cover the private cost of her care in the nursing home. Mother's will leaves her estate in equal shares to her four children.

Only Lyle is present in the long term care consultation. He says his siblings "don't seem to care" what happens to Mother and he has to "take care of everything". He states that as the POA he is in charge and he will make the decisions. He explains that Mother "has dementia" and "would not understand any of this."

In the course of the consultation, you cover the asset preservation technique of transfer and cure, also know as "reverse half loaf". You explain that the gifting provision in the power of attorney allows Lyle to transfer Mother's assets to himself and/or his siblings. There is no requirement of equalization of gifting in the POA. You advise him that the transferred resources will create a period of ineligibility for Medicaid and that he must be prepared to pay for Mother's care during this period until the ineligibility period is cured. You further advise him that the transferred resources should be held for the benefit of Mother without her having a direct ownership interest in the assets and that once Mother passes away any remaining assets should be distributed equally between his three siblings and him, as stated in Mother's will. You advise Lyle that the best vehicle for handling the transferred funds is a special needs trust for Mother's benefit, with Lyle as the trustee and which provides at Mother's death for the distribution of the remaining funds on the same basis as in her will. You offer to prepare the special needs trust for a reasonable flat fee.

Lyle declines your offer to have you draft a special needs trust and states he intends to hold them in an account in his name only. He takes your transfer and cure calculator schedule, pays his flat fee for the long term care consultation, and leaves. You have a sinking feeling that if there is anything left once Mother passes, he intends to keep it. You also know from your conversation with Lyle that he is recently separated from his wife and contemplating divorce. He also has had some setbacks in the market and is financially shaky.

1. Who is the client?

2. What is your duty if Lyle fails to take your advice on what he should do?

3. Should you tell Lyle's siblings what he intends to do?

4. Does it matter if you have seen an original of the POA, or if Mother is incapacitated or not?

ANALYSIS

Who is the client in this scenario, Mother or Lyle in his capacity as agent for Mother? NAELA Aspirational Standard B suggests that the lawyer identify the client "at the earliest stage of the representation." NAELA Aspirational Standard B(1). Some attorneys may not think there is a choice of who the client can be. However, "[w]hen an individual has appointed an agent through a power of attorney to act as his or her fiduciary, the attorney may identify the protected person, even though incapacitated, as the client even though the fiduciary retained the attorney. *Alternatively*, the attorney may treat the fiduciary as the client." NAELA Aspirational Standard B, Selected NAELA Comment E (emphasis added).

Rule 1.2, Scope of Representation, states that a "lawyer shall abide by a client's decisions concerning the objectives of representation" subject to some exceptions, including that a lawyer cannot counsel a client to engage, or assist a client, in conduct that the lawyer knows is criminal or fraudulent. The action Lyle proposes, transferring all Mother's money to himself, is within the scope of the unlimited gifting power in the power of attorney Mother gave to him. The fact that his action ultimately may thwart her estate plan if he does not share whatever money is left with his siblings is not *per se* illegal.

However, keeping all Mother's money for himself, of putting it at risk to his creditors or possibly subject to sharing with his soon to be ex-wife in a divorce action, may constitute a breach of his fiduciary duty (abuse of the confidential relationship he has with Mother as her agent). Has the attorney satisfied her duty by advising Lyle on the legal consequences of his proposed course of action - potential fraud, breach of fiduciary duty - if he does not safeguard the gifted funds for Mother's benefit during her life and sharing them with his siblings at her death?

Rule 1.2.(c) states

> A lawyer shall not counsel a client to engage, or assist a client in conduct that the lawyer knows is criminal or fraudulent, but a lawyer may discuss the legal consequences of any proposed course of conduct with a client or assist a client to make a good faith effort to determine the validity, scope, meaning or application of the law.

If Lyle is your client and you counsel him on the proper course of action, you have satisfied your obligation. How can you be held responsible for whether or not Lyle follows your advice or potentially wastes Mother's assets or cons his siblings out of their inheritance?

Under Rule 1.6, Confidentiality of Information, a lawyer is directed to not reveal information protected by the attorney-client privilege gained in the professional relationship without the consent of his client except in very limited circumstances. The exception at Rule 1.6(b)(3) states "to the extent the lawyer believes necessary, the lawyer may reveal: ... information which clearly establishes that the client has, in the course of the representation perpetrated upon a third party a fraud related to the subject matter of the representation". *See also* LEO 1643, where the Committee stated that the duty to disclose a client's confidence or secret to prevent fraud upon a tribunal exists only if the fraud occurred during the course of the attorney/client relationship.

This means the lawyer must first establish that:

1. The client has perpetrated a fraud (which is a legal determination of what is or is not actually "fraud"),
2. the fraud occurred DURING the course of the representation, not prior and is not going to occur in the future, and
3. the fraud is actually related to the subject matter of the representation.

Under this test, the exceptions are not satisfied. At this point, no fraud has been committed. This is just the potential for what would arguably be fraud. At the conclusion of the representation you know only what Lyle said he was going to do with the money: put it in an account in his name only. You do not know if he is going to fail to pay Mother's nursing home bill or not share what is left with his siblings when his Mother dies. At this point, no fraud has occurred so there is nothing to report. Moreover, the arguable fraud is not related to the subject matter of the representation which was Medicaid qualification and asset preservation.

Hypothetical 4

Ronald and Melanie come to see you for estate planning. Neither was married before this marriage and they have assets sufficient to trigger federal estate taxes. The meeting goes fairly smoothly and you forget to establish your relationship with them through a representation letter. Despite that oversight, you proceed to prepare their wills, powers of attorney and advance medical directives. You are fifteen minutes from completing their A-B revocable trusts and their irrevocable life insurance trust when Ronald calls.

He explains that he was recently in a chat room and he ran into an old girlfriend who now stars in adult films. She informed him that she has raised their son, who will turn 18 in a couple of months. She was so mad at him for how he treated her that she never told him about the child. Since the child and mother sound destitute, he wants to know how he can "divert" some of his assets to "take care of" the son once he dies. "Of course, Melanie does not need to know about this youthful indiscretion," says Ronald.

1. Can you help him provide for the son?

2. Do you have a duty to tell Melanie?

3. How should you proceed?

4. Would it matter if Ronald only wanted to benefit the son if Melanie predeceases him?

ANALYSIS

Rule 1.7 (a) states that "except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if: (1) the representation of one client will be directly adverse to another client; or (2) there is significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client . . . ." Rule 1.7(a).

Rule 1.7(b) states that "notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if each affected client

consents after consultation, and: (1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client; (2) the representation is not prohibited by law; and (3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and the consent from the client is memorialized in writing." Rule 1.7(b).

Whenever representing husbands and wives jointly, it is prudent to advise them that any confidences shared with you separately will need to be shared with the other spouse. "The prospective clients and the lawyer should discuss the extent to which material information imparted by either client would be shared with the other and the possibility that the lawyer would be required to withdraw if a conflict in their interests developed to the degree that the lawyer could not effectively represent each of them." ACTEC Commentaries on MRPC 1.7.

The ACTEC Commentaries provide that "the fact that the estate planning goals of the clients are not entirely consistent does not necessarily preclude the lawyer from representing them. Advising related clients who have somewhat differing goals may be consistent with their interests and the lawyer's traditional role as the lawyer for the 'family.'" ACTEC Commentaries on MRPC 1.7. "The fact that the goals of clients are not entirely consistent does not necessarily constitute a conflict that precludes the same lawyer from representing them. Thus, the same lawyer may represent both spouses, or parent and child, whose dispositive plans are not entirely the same." ACTEC Commentaries on MRPC 1.6.

"A lawyer who receives information from one joint client (the 'communicating client') that the client does not wish to be shared with the other joint client (the 'other client') is confronted with a situation that may threaten the lawyer's ability to continue to represent one or both of the clients. As soon as practicable the lawyer should consider the relevance and significance of the information and decide upon the appropriate manner in which to proceed." ACTEC Commentaries on MRPC 1.6. In such a situation, the Committee further explained that "the potential courses of action include, *inter alia*, (1) taking no action with respect to the communications regarding irrelevant (or trivial) matters; (2) encouraging the communicating client to provide the information to the other client or allow the lawyer to do so; and, (3) withdrawing from the representation if the communication reflects serious adversity between the parties." ACTEC Commentaries on MRPC 1.6.

The matter that Ronald has revealed is not irrelevant so the best course of action initially is to encourage Ronald to share this information with Melanie. "In order to

minimize the risk of harm to the clients' relationship and, possibly, to retain the lawyer's ability to represent both of them, the lawyer may properly urge the communicating client himself or herself to impart the confidential information directly to the other client." ACTEC Commentaries on MRPC 1.6. The lawyer "may mention that the failure to communicate the information to the other client may result in a disciplinary or malpractice action against the lawyer." ACTEC Commentaries on MRPC 1.6.

It is clear that you should not prepare his plan in a way that benefits the child and keep this information from Melanie. "Without the informed consent of the other client the lawyer should not take any action on behalf of the communicating client, such as drafting a codicil or a new will, that might damage the other client's economic interests or otherwise violate the lawyer's duty of loyalty to the other client." ACTEC Commentaries on MRPC 1.6.

If Ronald refuses, you are between the Scylla and Charybdis. The words chosen by the Committee indicate the difficulty: "If the communicating client continues to oppose disclosing the confidence to the other client, the lawyer faces an extremely difficult situation with respect to which there is often no clearly proper course of action." ACTEC Commentaries on MRPC 1.6. In expressing that the lawyer "should have a reasonable degree of discretion in determining how to respond to any particular case," the Committee stated that the following factors should be considered: (1) duties of impartiality and loyalty, (2) any express or implied agreement among the lawyer and the clients that information communicated by either client to the lawyer or otherwise obtained by the lawyer regarding the subject of the representation would be shared with the other client, (3) the reasonable expectations of the clients, and (4) the nature of the confidence and the harm that may result if the confidence is, or is not, disclosed. *See* ACTEC Commentaries on MRPC 1.6.

Given the nature of the confidence and the subject of this representation, you will likely reach the conclusion that you must withdraw if Ronald will not tell Melanie. Further highlighting the difficulty of this situation, the Committee cautions that "a letter of withdrawal that is sent to the other client may arouse the other client's suspicions to the point that the communicating client or the lawyer may ultimately be required to disclose the information." ACTEC Commentaries on MRPC 1.6.

"FORE! WELL, . . . MAYBE MORE?"

Hypothetical 5

You represent the beneficiary of the estate of a professional golfer who was once on track to win the most major tournaments in history. Due to the failure to settle certain claims, the estate is mired in litigation.

During a pre-trial hearing, the judge takes only the attorneys to his chambers. Opposing counsel surprises everyone by dropping photographs of people in compromising situations, allegedly of the golfer and multiple women, on the table. The photos are grainy and it is hard to tell whether they depict the golfer. The judge rules they are inadmissible and further orders the attorneys not to divulge the existence of the photos or the allegations they support with their clients. Opposing counsel is fuming and tells the other lawyers on the way back to the courtroom that a judge is not going to interfere with his client communications and says she will consider an ethics complaint against the judge.

1. Is the judge at risk for an ethical violation?

2. Is the attorney at risk for an ethical violation?

ANALYSIS

All three sections of Rule 1.4 dictate that the lawyer shall keep the client informed. Section (a) says "shall keep a client reasonably informed"; (b) says "shall explain a matter to the extent reasonably necessary" for the client to make an informed decision and (c) "shall inform the client of facts pertinent to the matter and of communications from another party that may significantly" impact the resolution of the matter.

However, Comment 7 to Rule 1.4 states that "Rules or court orders governing litigation may provide that information supplied to a lawyer may not be disclosed to the client". The Comment points out that Rule 3.4(d) "directs compliance with such rules or orders." Rule 1.4, Comment 7.

While unusual, the Comment is clear so the lawyer, not the judge, is the one at risk.

Hypothetical 6

You have represented Martha, a domestic living guru, in her capacity as executor of the estate of her late husband for the past five years. Her deceased husband's will provided for Martha and several other beneficiaries. You have learned that the other beneficiaries recently filed a lawsuit against Martha, alleging violations of securities law. She calls you and says that the beneficiaries have filed a motion to compel production of your files relating to your representation of her as executor.

Are the beneficiaries likely to succeed at the hearing on their motion to compel?

ANALYSIS

The above scenario concerns what is commonly known as the fiduciary exception to the attorney-client privilege. This exception acknowledges the interplay of the attorney-client privilege and the fact that the fiduciary owes duties of good faith, trust and candor to the beneficiaries. This exception was created in the corporate context. The Fifth Circuit Court of Appeals developed a test to determine when shareholders could obtain access to communications between corporate management and the corporation's lawyer in Garner v. Wolfinbarger, 430 F.2d 1093 (5th Cir. 1970). Since then, the exception has been applied to bank directors, union members, ERISA plan beneficiaries, partners, insureds, and trust beneficiaries.

The above scenario is from Lawrence v. Cohn, 2002 U.S. Dist. LEXIS 1226 (S.D.N. Y. 2002), wherein the law firm of Weil, Gotshal & Manges ("WGM") was forced to produce most of its files to the beneficiaries. The court stated:

> WGM represented Cohn [executor] in that case only in his capacity as executor. In that capacity, he owed certain fiduciary responsibilities to the estate, and, thus, to its beneficiaries. Given these obligations, he cannot assert the privilege, nor can WGM invoke the work-product rule, against the estate or its beneficiaries. . . . When a fiduciary retains an attorney to advise him in the exercise of his fiduciary responsibilities, his communications with that attorney are not absolutely protected from inquiry by the beneficiaries for whom the fiduciary performs. This principle is recognized in a variety of contexts, although the prototype finds its source in the law of trusts.

Id. at *9. The court also required the law firm to produce its time and billing records, pursuant to the fiduciary exception and based on the rationale that the firm did not have a reasonable expectation of confidentiality since it would need to produce them in order to be reimbursed for its expenses. Id. Accordingly, the beneficiaries will most likely succeed at the hearing.

Hypothetical 7

You represented Aretha for many years and prepared her will. She recently died and her beneficiaries have informed you they intend to initiate litigation in order to clarify the terms of the will. They indicate that they intend to seek production of your files and to elicit your testimony regarding communications you had with her in the upcoming proceedings. You tell them that you will remain neutral in the matter. You further state that you will not produce the files and that you will not testify because the attorney-client privilege survives death.

Will the heirs be able to obtain your files and elicit your testimony regarding these communications?

ANALYSIS

One exception to the principle that the attorney-client privilege survives death is where the communications are necessary to ensure that the client's testamentary intent is satisfied. The Supreme Court of Virginia has stated:

> It may be laid down as a general rule of law, gathered from all the authorities, that unless provided otherwise by statute, communications by a client to the attorney who drafted his will, in respect to that document, and all transactions occurring between them leading up to its execution, are not, after the client's death, within the protection of the rule as to privileged communications in a suit between the testator's devisees and heirs at law, or other parties who all claim under him. The reason for such an exception to the general rule excluding confidential professional communications is that the rule is designed for the protection of the client, and it cannot be said to be for the interest of a testator, in a controversy between parties all of whom claim under him, to have those declarations and transactions excluded which are necessary to the proper fulfillment of his will . . . . After the death of the client, however, it has been held that the privilege may be waived when the character and reputation of the deceased are not involved, by his executor or administrator, or in will contests by his heirs or legatees.

Hugo v. Clark, 99 S.E. 521, 522 (Va. 1919). *See also Restatement (Third) of Law Governing Lawyers,* Section 81, at 612 (1998)("The attorney-client privilege does not apply to a communication from or to a decedent relevant to an issue between parties who claim an interest through the same deceased client, either by testate or intestate succession or by an inter vivos transaction.").

Your files will most likely be turned over and you will most likely testify.