NYSBA FALL 2004 | VOL. 14 | NO. 4

# Elder Law Attorney

A publication of the Elder Law Section
of the New York State Bar Association

## Message from the Chair

The sun has set on our 2004 Elder Law Section Summer Meeting. Mohegan Sun served as our forum for the meeting, and if it is true that "the quality of a person's life is in direct proportion to their commitment to excellence" (Vince Lombardi), then our Section should be very proud. By all accounts, our 2004 Summer Meeting was of the highest quality and met the highest standards of excellence. With over 200 lawyers assembled (one of the largest attendance of attorneys for a Summer Meeting in the history of the Section), we were treated to outstanding presentations by Section members and well-known, non-member speakers alike. The program featured up-to-date information regarding recent developments in elder law, changes to the Medicare program, long-term care reform, supplemental needs trusts, estate planning, contested probate proceedings, nursing home placement issues, Medicare and Medicaid fraud issues, and guardianship issues. William Colby, author of *The Long Goodbye: The Deaths of Nancy Cruzan*, was a featured speaker, as was Ed Slott, author of *Ed Slott's IRA Advisor*.

On behalf of the Section, I extend my heartfelt thanks to Timothy Casserly for serving as Chair of our Summer Meeting and to Kathy Heider, our Meetings Coordinator at the New York State Bar Association, who did an exceptional job of carrying out our vision for this program.

Much is happening in New York State both legislatively and within our Section as I write this in mid-September. On August 11, 2004, Governor Pataki signed into law S.6058-B, the 2004-2005 budget bill. None of the restrictive Medicaid eligibility provisions made it into the final bill presented to the Governor. As is discussed in this issue's Legislative News column, the final bill contained numerous provisions pertaining to long-term care insurance (education of consumers, increasing accessibility, etc.). In addition, Partnership policies were made portable amongst the three other Partnership states (California, Connecticut and Indiana). Furthermore, the final bill signed by Governor Pataki increased from 10% to 20% the state tax credit for long-term care insurance premiums paid.

I'd like to take this opportunity to thank our lobbyist, Harold Iselin; Ronald Kennedy, NYSBA Associate Director of Governmental Relations; A. Thomas

## Inside this Issue

Levin, Immediate Past President of the NYSBA; Patricia Bucklin, Executive Director of the NYSBA; John Williamson, Associate Executive Director at the NYSBA; our Section's Immediate Past Chair, Joan Robert; Daniel Fish and Vincent Russo, who served so ably as co-chairs of the Special Committee on Medicaid Legislation; and all of the members of that committee, which include: Cora Alsante, Louis Pierro, Ellen Makofsky, Lawrence Davidow, René Reixach and Ronald Fatoullah.

A special thanks also goes out to Brian Lindbergh, Public Policy Consultant to the National Academy of Elder Law Attorneys, whose input throughout this process was invaluable, as was material provided to us by the National Academy of Elder Law Attorneys in our efforts to oppose the proposed legislation.

I wish I could say that this chapter of our Section's history has now come to a close. Unfortunately, the last eight months was but one battle in a war that is likely to reignite next January, when Governor Pataki proposes the 2005-2006 budget bill. We are already preparing for this fight. I have appointed Daniel G. Fish to Chair our Section's Lobbying Committee. Dan's committee has prepared a position paper which is being submitted to the New York State Bar Association's Steering Committee on Legislative Priorities in support of the Association's continued retention of a lobbyist to address proposals to finance long-term care. Furthermore, A. Vincent Buzard, President-Elect of the Association, will be joining our Section's Officer and Executive Committee Meetings in Rochester. Mr. Buzard was the Chair of a Special Committee on Legislative Advocacy which rendered a report to the House of Delegates in January 2002. We will also be joined at our October 21 Executive Committee Meeting by lobbyist Harold Iselin, who was instrumental in guiding the Section in its opposition efforts regarding the 2004-2005 budget bill. Our goal is to develop a strategy that will address the need to increase the advocacy efforts of the Section, thereby benefiting our Section membership and the elderly clients whom we serve. I will keep you posted as things develop in this area.

Our committees are extremely busy working on a variety of projects:

1. The Long-Term Care Reform Committee (Lou Pierro, Chair; Robert J. Kurre, Vice-Chair), is in the process of revising its Long-Term Care Reform Report, which will assess how we deliver health care services in New York State and nationally. The Report will make specific recommendations regarding how we can improve the current health care system as well as outline changes that need to be made in order to achieve such improvements. This Report will be a critical aspect of the Section's future lobbying efforts.

2. The Financial Planning and Investments Committee (Timothy Casserly, Chair) is currently leading an effort to create a brochure advising seniors of the potential pitfalls of purchasing an annuity. This endeavor is being undertaken to address concerns expressed by Section members regarding aggressive sales tactics utilized in conjunction with the sale of annuities to our senior clients. The Client and Consumer Issues Committee (Meg Reed, Chair; Fran Pantaleo, Vice-Chair) and the Insurance Committee (Bruce Birnbaum, Chair) will be assisting in this project.

3. The Real Estate and Housing Committee (Neil Rimsky, Chair; Marcia Boyd, Vice-Chair) is currently working on a brochure that will educate the public about assisted living facilities now that the Assisted Living Reform Act has become law and we have licensing and disclosure requirements for such entities in New York State.

4. The Client and Consumer Issues Committee (Meg Reed, Chair; Fran Pantaleo, Vice-Chair) is preparing a brochure on Long-Term Care Insurance with assistance from the Insurance Committee (Bruce Birnbaum, Chair). Once complete, this brochure will be distributed to consumers who are interested in learning about long term care insurance.

5. The Family Law Committee (Rita Gilbert, Chair) is working with the Guardianship and Fiduciaries Committee (Charles Devlin, Chair; John Dietz, Vice-Chair; Anthony Enea, Vice-Chair; and Ira Salzman, Vice-Chair) in an effort to achieve an integrated guardianship part, which would allow guardianship judges to hear all matters pertaining to incapacitated persons. Should this effort prevail, attorneys would no longer find themselves in multiple forums before multiple judges to address the variety of issues confronting incapacitated persons (i.e., family law issues, landlord-tenant issues, etc.).

6. The Communications Committee (Steve Rondos, Chair; Dean S. Bress, Vice-Chair) has been working hard on the second issue of the Section's e-News, which is scheduled to be sent to Section members via e-mail in early October. The first e-News was issued in July 2004 and received rave reviews. If you did not receive

*(Continued on page 44)*

# Editor's Message

Have we all finally had enough of the all-important debate regarding the Vietnam-era service of President Bush and Senator Kerry? When are we going to hear about REAL issues? Of course, national security, the wars in Iraq and Afghanistan, and the fight against terror must be the priorities. But there has been little discussion of any other issue. Where do the candidates stand on Social Security, much-needed reforms in Medicare, ensuring that the new prescription drug program will actually work, and long-term care? Hopefully, the upcoming debates will force the candidates to address these important issues, and by the time this issue of *Elder Law Attorney* is published, our nation can move forward towards meaningful reform. Although it may not be the top issue of discussion during this campaign season, there have been numerous developments of interest to elder law attorneys and our clients by way of legislation that passed (and did not pass).

Greg Olsen is the Legislative Director for New York State Assemblyman Steve Englebright, Chairman of the Assembly Committee on Aging, and has written an article that provides an excellent summary of this year's legislation of interest to seniors. Mr. Olsen also discusses the creation of new programs as well as the effects of legislation on existing programs.

Darlene M. Jyringi, MPS is the Program Director of the Alzheimer's Disease Assistance Center of Long Island, and she reports that by 2050 it is estimated that 16 million Americans could have this devastating illness. She has contributed an article discussing the new developments in the fight against Alzheimer's Disease.

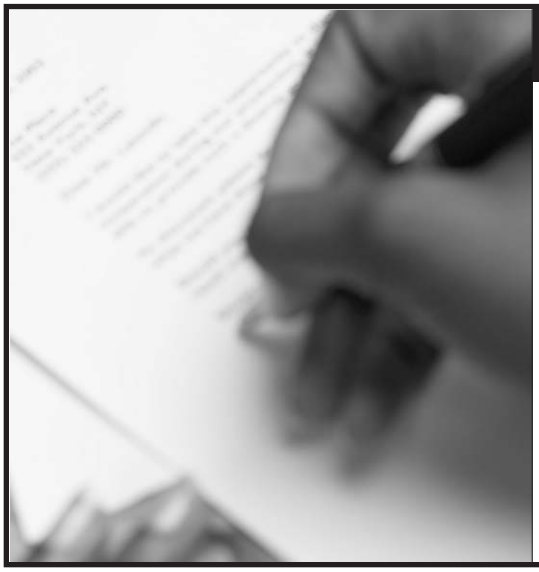
Barbara Wolford, LPN is the Director of Elder Care Services for Davidow, Davidow, Siegel and Stern, and has provided a listing of some of the questions and answers that are so important for caregivers. Elder law attorneys must be aware of the challenges caregivers face every day in caring for an elderly loved one. These suggestions should provide helpful guidance.

Paul Arfin has been in the forefront of intergenerational issues and solutions. As the President and CEO of Intergenerational Solutions, he has firsthand experience with the benefits of intergenerational programs. His article begins a dialogue on how best to create and implement programs that will benefit not only the elderly, but all generations.

As always, this edition's NEWS section contains timely and useful articles by some of the most experienced practitioners in our Section. Thanks to all of them for their continued commitment.

Please enjoy this edition of *Elder Law Attorney*.

**Steven Stern**



## Request for Articles

If you have written an article, or have an idea for one, please contact the new *Elder Law Attorney* Editor

Steven M. Ratner, Esq.
Law Office of Steven M. Ratner
One Barker Avenue, 4th Floor
White Plains, NY 10601
(212) 754-9117

*Articles should be submitted on a 3½" floppy disk, preferably in Microsoft Word or WordPerfect, along with a printed original and biographical information.*

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# ELDER LAW NEWS

## REGULAR COLUMNS

# Fiscal Year 2004/05—Final Budget Agreements

By Greg Olsen

Newspapers have claimed that this year's legislative session was short on substance. Readers can decide for themselves on the merits of these statements. What is clear, however, is aging issues had an historic year with numerous accomplishments that we can and should be proud of. These accomplishments are due, in large part, to the strong working relationship between Assembly Aging Committee Chair Steven Englebright, Senate Aging Committee Chair Martin Golden and their staffs, as well as the hard work and dedication of Assembly Health Committee Chair Richard Gottfried and his staff and Assembly Insurance Committee Chair Pete Grannis and his staff. Furthermore, Assembly and Senate program staff proved invaluable and should also be commended for their expertise and hard work.

A wrap-up of the significant achievements of this session are outlined below.

The Assembly pushed hard for restorations to the New York State Office for the Aging's Budget. The Governor proposed just under a $1 million cut to the Community Services for the Elderly Program (CSE), the Expanded In-Home Services for the Elderly Program (EISEP) and the Long-term Care Ombudsman Program. The effect of these cuts would mean fewer needy seniors receiving home-delivered meals, less access to transportation, less social adult day care, less respite for caregivers, and less personal care to help seniors remain independent. And, of course, the Long-term Care Ombudsman Program is very important in helping nursing home residents ensure that they receive the quality of care that they deserve.

These cost-effective, community-based support programs help seniors remain independent with dignity and help keep older New Yorkers from applying for Medicaid. These programs actually save money by reducing hospitalizations and nursing home placements and therefore save the state significantly in Medicaid dollars. They should be expanded, not cut.

The legislature again rejected the Governor's proposed cuts and restored about $1 million in funding to the:

- **Community Services for the Elderly Program** (CSE provides a flexible funding stream to local communities to provide a variety of supportive services designed to help a senior maintain their independence and support caregivers.) The proposed cut of **$202,215** was restored.
- **Expanded In-home Services for the Elderly Program** (EISEP provides older, frail non-Medicaid eligible seniors with non-medical in-home support services that keep them living at home—services include help with personal care, homemaking and chores, case management, respite, etc.) The proposed cut of **$528,030** was restored.
- **Long-term Care Ombudsman Program** (provides training to volunteers who go into nursing homes and help the administration and the residents work out differences, complaints and other problems). The proposed cut of **$58,400** was restored.
- **Respite Program** (provides caregivers with time to take a break from the rigors of being a caregiver). The proposed cut of **$175,000** was restored.

## Pharmacy Reimbursement Rate Cuts

The Governor, in an effort to save the state money, proposed to reduce the amount of money that the state would reimburse pharmacies for Medicaid and the Elderly Pharmaceutical Insurance Coverage program (EPIC). While pharmacy expenses for the state continue to rise, going after community pharmacies is the wrong strategy. New York should be developing and implementing strategies to use its size and clout to bulk-purchase on behalf of its residents. A recent study by the Boston University School of Public Health found that New York and New Yorkers could save $4.7 billion annually if it received rates equivalent with the federal supply schedule.

Assemblyman Englebright led an effort in the Assembly to reject these proposed reimbursement rate cuts that would have made it harder for community pharmacies to remain in business. The impact of this could have meant that seniors and other individuals, particularly in more rural areas, would not have had access to a community pharmacy and the pharmacists that they have long-standing relationships with. While the Assembly and Senate were not successful in restoring all the cuts, we were able to restore 75%.

We are deeply concerned about the potential loss of access to licensed, knowledgeable health care professionals in the community who have long-standing relationships with individuals, are available in emergencies, provide important guidance and monitoring to patients and their caregivers and have earned the trust of their patients, particularly senior citizens. Cutting reimbursement rates further could result in losing access to the local pharmacy and to the local pharmacist. This places an undue burden on seniors who may not be able to travel to neighboring towns or villages to get their medicines.

The Governor proposed to cut brand name drugs—from Average Wholesale Price (AWP)-12% to AWP-15%. The legislature restored 75% of the proposed cut so the new reimbursement rate will be AWP-12.75%.

The Governor proposed to cut generic drugs from AWP-12% to AWP-30%. The legislature restored 75% of the proposed cut so the new reimbursement rate will be AWP-16.5%

## Medicaid Long-term Care Changes

Based on the Governor's and the Senate's Medicaid Task Force Recommendation, proposed changes were forwarded for Medicaid long-term care. The theory backing these proposals centered around wealthy individuals who hide their assets to qualify for Medicaid. While we wholeheartedly agree that individuals with means should contribute to their long-term care costs, the proposals to change Medicaid long-term care would not have solved the problem and the impact of the proposed changes would have significantly hurt low and moderate-income seniors.

Assemblyman Englebright considered rejecting these proposals his top priority. With the help of other members of the Assembly and many of the advocates for the elderly, these proposals were rejected by both the Assembly and reluctantly, the Senate.

The Governor's proposed changes in Medicaid long-term care included:

1. Eliminating a well spouse's right to refuse;
2. Increasing the look-back period for asset transfers and fits from 36 to 60 months;
3. Instituting a look-back period of 60 months for home care;
4. Commencing the penalty period for an asset transfer or gift to the time the individual needs care rather than when the transfer was actually made.

## Effect of Proposed Changes

- The effect of eliminating spousal refusal in the community is that non-Medicaid spouses who cannot afford to live on the Medicaid couple budgeting of $950 in monthly income and resources of $5,700 may have to place the ill spouse in a nursing home, a violation of the *Olmstead* Supreme Court decision.
- Ill spouses in need of community care may be forced to forgo care because it is unaffordable, thereby turning an individual's manageable problem into one that is more chronic and more expensive to treat.
- Care provided by the non-Medicaid spouse (caregiver), estimated to save New York over $11 billion per year, is likely to be significantly diminished if a non-Medicaid spouse is forced, prematurely, to send the ill spouse to a nursing home.
- Spouses who have been married for many years will be saddled with the decision of whether or not to divorce in order to get the community care they need.
- Medicaid costs will rise as cost-effective care that could have been provided in the community is shifted to significantly more expensive institutions.

Spousal refusal protections were put into place to ensure that seniors do not become impoverished should only one spouse need care. They will only harm our older and younger constituents.

While we are all looking for ways to reduce state and county Medicaid costs, these proposals will not meet these goals. Indeed, we believe they will actually increase Medicaid costs by pushing seniors, prematurely, into institutions to receive the care they need. This almost inevitable outcome violates the *Olmstead* Supreme Court decision. Providing cost-effective community services is the best way to lower state and local Medicaid costs, while remaining compliant with the *Olmstead* decision.

## Additional Long-term Care Changes

Assemblyman Englebright introduced four separate bills this session that would encourage the purchase of long-term care insurance, develop an outreach and education program, develop a new reverse mortgage program through New York State to allow seniors to use the equity in their homes to stay in their homes, and study a universal approach to long-term care. Three of his proposals are contained in the final budget after some tinkering during budget negotiations with the Senate.

Long-term care changes that were included in the final budget include:

1. An increase, from 10%–20%, in the **tax credit** off the total yearly policy premium for individuals purchasing long-term care insurance.
2. Authorizing the commissioner of health and the insurance commissioner to work with other states that administer **partnership for long-term care plans to be portable** (Medicaid benefits paid to other states rather than mandating the recipient move back to New York to receive benefits).
3. **Third party notification**—insurers offering long-term care insurance policies in New York shall permit seniors to designate a third party to whom the insurer shall transmit notices of non-payment of premiums due or notice of cancellation for nonpayment. The purpose is to cut down on lapse in payments for a variety of reasons.
4. Creates the **long-term care outreach and education program**—$5 million in new funding is available with just over $3 million for the New York State Office for the Aging to hire a full-time coordinator and implement the local program aspect.
   - Grants up to $50,000 are available to each county office for the aging to set up and administer the long-term care insurance resource center whose purpose is to be proactive in the community to educate the public about long-term care insurance options, the need to plan for one's long-term care, services available and their various financing mechanisms, etc. (Micro)
   - Resource centers will have at least one full-time coordinator.
   - Outreach includes print, audio, and video educational information.
     - PSAs, ads, media campaigns, conferences, presentations, trainings
     - Toll-free hotline
     - Counseling, information, referral services—direct assistance
   - $1,950,000 is available for DOH, NYSOFA and DOI to develop and implement statewide media campaign, information and outreach development and distribution (Macro).

## Assisted Living

Certainly the crowning achievement of this session after five years of logjam, an assisted living bill was passed on the last day of session. Unregulated assisted living facilities have been growing rapidly throughout New York State and problems have arisen in some of these facilities. Legislation has been needed to provide licensure and adequate state oversight to ensure that the residents' health and safety are maintained.

The legislation, known as the Assisted Living Reform Act, establishes a uniform licensing procedure for assisted living facilities. It also requires important consumer disclosures and sets forth a clear set of consumer rights, protections and safeguards so residents and their families can be sure they're getting quality care and service. The legislation:

- Clearly defines "assisted living residences";
- Clearly defines "aging in place";
- Requires that residences advertising or marketing themselves as serving individuals with dementia and cognitive impairments submit

special needs plans outlining their ability to serve such vulnerable individuals;

- Requires assisted living facilities to be licensed with the Department of Health;
- Requires each facility to conspicuously post the residents' rights;
- Requires the execution of a written residency agreement with each resident;
- Sets guidelines regarding the management of a resident's money and personal property;
- Requires facilities to assist in the development and operation of resident and family councils; and
- Sets uniform guidelines for the admission, discharge and transfer of residents.

The bill also creates a Task Force on Adult Care Facilities and Assisted Living to recommend changes to cut red tape and to better promote choice, autonomy and independence. The task force will also gather information on rules that make care and services less affordable and will direct the Health Department to develop standards for staffing and training for facilities serving individuals with cognitive impairments.

### Forge-Proof Prescription Forms

New York passed language in the budget to develop and implement forge-proof prescription drug forms to reduce fraud and to cut down on prescription drug errors. The official forms will be serialized, will be non-reproducible or transferable. In addition, Medicaid and EPIC prescriptions will be allowed to be submitted electronically (ordering or refilling).

### Adult Homes

The legislature increased SSI payments to adult home providers (Level II) by $7 over two years and increased the personal needs allowance for the residents. Seven million in new money was also provided for improvements to the quality of life for residents.

### Adult Home Reforms

The Assembly would not do the SSI increase for providers without some adult home reforms. The reforms that were agreed upon did not go as far as the Assembly would have liked but they are improvements. They include:

- Prohibition on hospitals discharging patients to a facility (adult care facility) on the do-not-refer list (unless they lived there prior to hospital admission)
- Hospitals, Department of Correctional Services, Office of Mental Hygiene, state Division of Parole will be notified of facilities on the do-not-refer list and will be prohibited from making referrals when the facility is on the do-not-refer list, when the facility has received written notice of proposed license revocation, suspension, denial, or the limitation of the operating certificate or when assessment of civil fines is made.
- The Department of Health must maintain on its website a list of all adult care facilities that have received written notice of enforcement actions for violations that create endangerment of resident health and safety, or a pending enforcement action against facilities operating certificate.
- If the facility corrects the problem, the Department shall reinspect the facility within 30 days and if it agrees that the problem has been corrected, the facility shall be removed from the list.
- Operator cannot apply for an operating certificate in New York to operate an alternative facility while their current certificate has been revoked, suspended or limited.
- Creates temperature standards in all occupied areas of the adult care facility and requires the common room to be air conditioned.
- Creates the adult home quality enhancement fund—Comptroller and Taxation and Finance—DOH gives it out to promote programs to improve the quality of care in adult homes.

### Disease Management Demonstration Program

Up to six programs through an RFP process will be authorized for Medicaid patients to better coordinate and manage their care, reduce costs, reduce hospital utilization, and reduce lengths of stay in hospitals.

To be eligible to participate, an individual must be Medicaid eligible; a dual eligible (Medicaid and Medicare) are not in Medicaid managed care and are diagnosed with chronic health problems. Enrollment is voluntary and once in, can opt out at any time.

The disease management entity will be paid a capitated rate per month per enrollee—not to exceed 95% of the Medicaid rate for that individual. Three million dollars is appropriated for the demonstration.

### Telemedicine Demonstration Program

The purpose is to improve the use of technology to improve home care service quality. Projects eligible will apply based on an RFP and must be licensed home care agencies.

The demonstration will be based on using technology to monitor patients in the home, to enhance collaboration and communication among the home care aide, supervising nurse, primary care physician and other providers.

Two million dollars was appropriated for this demonstration.

### Grants for Long-term Care Demonstration

This demonstration requires the Department of Health to apply for a Medicaid waiver for the purpose of encouraging community-based programs and smaller residential health care models in order to promote consumer choice, to ensure the recruitment, retention and training of staff to adequately meet the needs of community ands residential LTC system. There are two separate demonstration programs.

1. **Residential health care demonstration program:**
   - Where there is a reduction in the number of skilled nursing beds, design and develop smaller residential facilities as an alternative to replacing a facility.
   - Promote quality, efficiency and continuity of care by developing integrated LTC services in the community.
   - Provide training of staff for LTC services.
   - Include workforce in the development and design of program.
   - Develop new reimbursement methodology that encourages care in the least restrictive environment and adequately reflects the resources necessary to serve consumers in the setting.
   - Evaluation of program.
2. **Community-based care demonstration program:**
   - Where reduction in NH beds in county, develop new system to inform recently admitted residents of the availability of community LTC options.
   - Discharge planners in skilled nursing facility will inform, assist and maximize freedom of choice to consumers who choose to transition back to community.
   - Develop funding for recruitment, retention and training of workers to increase community-based services.
   - Evaluation of program.

### Key Legislation that Passed this Session

**A.11350-A, Cahill, Englebright/S.7073 Meier—Nursing facility transition and diversion Medicaid waiver**

This historic legislation directs the Department of Health to apply for a nursing facility transition and diversion waiver from CMS to identify individuals of all ages with disabilities in nursing homes who do not need to be there and transition them back into the community. The waiver would finance this transition and provide community-based support services that will help persons of all ages live in the most integrated setting, their homes. This bill is an important step in rebalancing the long-term care system and complying with the *Olmstead v. L.C.* Supreme Court decision of 1999.

***Status—passed both houses, awaits Governor's signature/veto***

**A.9587-C, Englebright/S.6007-C, Golden**—Establishes the senior citizens bill of rights in statute. This bill establishes in statute a senior citizens bill of rights and directs the state to report on these rights in their policy development and implementation, focusing on the independence, dignity and contributions that older New Yorkers provide to New York.

***Status—passed both houses, awaits Governor's signature/veto***

**A.9708, Englebright/S.6004, Golden**—Creates the Elder Law. This legislation creates a new "Elder Law" by moving the various statutes into one new statute. New York lacks an Elder Law, which would provide a new level of focus on issues affecting the state's seniors. The result is varying definitions of what constitutes a senior and in targeting programs for seniors. Creating a New York Elder Law is the first step in beginning to straighten out and better target policy and programs for seniors.

***Status—passed both houses, awaits Governor's signature/veto***

**A.2350-A, Englebright/S.2223-A, Golden—**Requires adult homes to display a long-term care ombudsman poster in a prominent public area and to distribute long-term care ombudsman brochures to residents upon request.

***Status—passed both houses, awaits Governor's signature/veto***

**A.10876 Rules Englebright/S.6781, Golden**—Extends the provisions of the combined senior citizen services center/residential health care facility/child day care community grants program from December 31, 2004 until December 31, 2006.

### Passed Assembly

**A.1131 (Sidikman)** requires local governments to notify their residents of the availability of the senior citizen real property tax exemption 30 days prior to the filing deadline and allows seniors to apply for this exemption 60 days after the filing deadline if they have received this exemption before.

**A.1432-A (Lentol)** authorizes SOFA to establish one or more senior pet companionship programs.

**A.2345 (Englebright)** authorizes SOFA to establish the Senior Vision Services program.

**A.2560 (Gianaris)** allows localities to exclude all medical and prescription drug expenses not reimbursed or paid for by insurance when determining income eligibility for the Senior Citizen Rent Increase Exemption program (SCRIE).

**A.4847 (Pretlow)** allows localities to exclude up to $15,000 of income earned from a disability pension or benefit when determining income eligibility for the Senior Citizen Real Property Tax Exemption program.

**A.6929 (Carrozza)** allows municipalities to adopt a 14-tiered sliding scale SCRIE benefit.

**A.8473-A Rules (Bing)** allows local governments to exclude 100 percent of Social Security income when determining income eligibility for the SCRIE program.

**A.9519 (Gunther, A.)** allows localities to provide a five-day extension to pay real property taxes for seniors who are receiving an enhanced STAR exemption.

**A.10540-A (Grannis)** ensures that residents of nursing homes who are enrolled in the EPIC program can continue to access their prescription drug coverage under this program.

## Health Committee

### Passed Assembly

**A.8022-B Rules (Gottfried)** requires the Department of Health (DOH) to collect nursing home data for dissemination to consumers and establishes a nursing home quality improvement fund.

**A.8689-A Rules (Gottfried)** provides for important adult home reforms.

**A.8621 (Rivera, P.)** establishes a private right of action for residents of adult homes to petition for temporary or permanent receivership.

**Greg Olsen is the Legislative Director for Assemblyman Steven Englebright, Chair of the Assembly Committee on Aging. Prior to joining the staff of Assemblyman Englebright, Greg served as the Executive Director of the New York State Alliance for Retired Americans and the New York State Coalition for the Aging; he was the Associate Director for the New York StateWide Senior Action Council. Greg has over 10 years of experience in the field of aging in New York and he has been a frequent contributing writer to this journal.**

**Greg received his Masters Degree in Social Work from Syracuse University with a specialty in Gerontology from the Maxwell School.**

# New Developments in Alzheimer's Disease

By Darlene M. Jyringi, MPS

Alzheimer's disease (AD) is the most common cause of dementia in people aged 65 and older. Experts believe that an estimated 4.5 million Americans have AD and that number will continue to grow as large numbers of baby boomers are entering the years when they are at highest risk for the disease. By 2050 it is estimated that 16 million Americans could have this devastating illness (Herbert 2003).

The cause of Alzheimer's disease remains a mystery. While age is considered the primary risk factor for developing the disease, other factors are emerging. AD is now thought to be a genetically complicated and heterogeneous disorder that may be the result of a sequence of poorly understood steps in a microorganism or a substance capable of producing the disease (Lahiri 2004).

Our brains are made up of billions of nerve cells called neurons. They are the structural and functional units of the nervous system. Groups of neurons in the brain have specific jobs. Some are involved with thinking, learning and memory. Some receive sensory information while others are responsible for communicating with our muscles. To prevent their own death, neurons must constantly maintain and remodel themselves. If cell cleanup and repair slows or stops for any reason, nerve cells cannot function and will eventually die.

Alzheimer's disease disrupts the processes that keep neurons healthy: metabolism, communication, and repair. The destruction and death of nerve cells causes memory loss, changes in personality, and difficulty in performing our daily activities. The brains of AD patients have an abundance of two abnormal structures, beta-amyloid plaques and neurofibrillary tangles. This is especially true in regions of the brain crucial for memory. Plaques are insoluble deposits of protein and cellular material around and outside the neurons. Tangles are insoluble fibers that build up inside the nerve cell. Their role in AD has become the focus of numerous research studies.

Medications currently prescribed for AD treat only the symptoms but do not stop the progression of the disease. Drug discovery has been limited due to a lack of relevant cell lines and animal models to screen drug candidates. Recently, a privately held drug and discovery company successfully cultivated screening assays in cell types relevant to AD. Mice that produce beta-amyloid plaques are now being generated. The development of another type of mouse that has both plaques and tangles provides some understanding of how these relate to each other. *In vivo* models in mice and rats are under development and the approaches refined here may be extended to other pharmacologically desirable species.

NC758 is an experimental drug that is currently in Phase III clinical human trials. Preliminary results suggest that NC758 interferes with the ability of beta-amyloid proteins to adhere to each other to form plaques. Researchers report that the drug was found in the cerebrospinal fluid which suggests that it successfully crossed from the blood to the brain. In addition, levels of beta-amyloid protein circulating in the cerebrospinal fluid were reduced after three months of treatment, suggesting that the brain may have experienced less amyloid accumulation.

In animal studies, drugs called protein kinase C activators appear to attack the cause of AD as well as the symptoms. An account in the *Proceedings of the National Academy of Sciences* (July 27, 2004) reports that an enzyme, PKC, appears to play a role in the memory loss and protein buildup that causes AD. The effects of two PKC activators were assessed in cell cultures and in mouse models of AD. In cell cultures, the activators produced chemical changes that could have beneficial effects in patients with AD. In mice, the activators reduced protein buildup in the brain and helped to prevent premature death while improving behavioral outcomes.

Scientists at the University of California, Irving, report that antibodies to beta-amyloid clear up extracellular amyloid plaques and promote the clearance of intracellular neurofibrillary tangles. Animals were injected on one side of their brains with the antibodies and examined one week later. A significant reduction in the number of plaques on the treated side as

contrasted to the side that did not receive the antibodies was found. In addition, there was a reduction in the intracellular aggregates of tau, the major component of neurofibrillary tangles (Neuron 2004). Whether immunization against beta-amyloid would have such exciting effects in humans remains to be seen.

Scientists from the Cleveland Clinic Lerner Research Institute have found that reticulom, a molecule known for its ability to regulate nerve regeneration, may hinder the progression of AD. They are now seeking ways to increase this interaction (Cleveland Clinic News 2004).

Eli Lilly and Company researchers are using a more extreme experimental approach to reducing beta-amyloid in the brain by preventing the protein from forming in the first place. Their strategy interferes with a series of enzymes called secretases, which make beta-amyloid, by cutting it from a much longer protein called the amyloid precursor protein (APP). Safety is of particular concern with secretase because inhibiting this enzyme may interfere with other fundamental physiological processes and produce unsuitable side effects.

Scientists at Washington University School of Medicine in St. Louis reported in *Science* (Aug. 13, 2004) that a protein linked to increased lifespan in worms and yeast can delay the degeneration of ailing nerve cell branches. If this mechanism can be activated by genetic or pharmaceutical treatments, it might open the door to new ways to treat neurodegenerative disorders, including AD.

Early studies of estrogen for the prevention of AD were promising. However, a clinical study of several thousand postmenopausal women aged 65+ found that combination therapy with estrogen and progestin substantially increased the risk for AD. A current clinical trial is studying the effect of estrogen alone to decrease the risk for AD.

Insulin resistance is not uncommon in patients with AD. A low level of an enzyme that reduces amyloid-beta peptides also reduces insulin. When amyloid-beta levels rise, one's risk for AD also rises. Researchers are now determining if low insulin levels actually result in an increased risk for AD.

Statins, cholesterol-lowering agents, have generated interest as a possible preventative strategy for AD. Researchers have found that four different statins reduce, to varying extents, the brain cells' production of a protein fragment that is thought to play a role in AD. An analysis of all existing randomized controlled trials of statins in people without dementia (30,000+ participants) found no evidence that any statin protects against cognitive decline. Although research indicates conflicting results, there has been evidence of some biological mechanisms that may account for the preventive benefit. Large-scale trials are needed to resolve these controversies.

A few alternative studies are underway. A report in the August 2004 issue of the *Journal of Neurology, Neurosurgery, and Psychiatry* suggests that a high intake of niacin, particularly from food sources, may reduce the risk of AD and age-related cognitive decline. Severe niacin deficiency is known to cause dementia. Food frequency questionnaires and cognitive tests were administered to several thousand elderly residents of a Chicago community. At baseline, the randomly selected subjects were all free of Alzheimer's disease. Approximately four years later, 131 of the subjects were diagnosed with AD. In this study population, a high level of total niacin intake appeared to protect against both AD and cognitive decline. Niacin intake from foods rather than supplements had a stronger correlation.

In Pittsburgh, ginkgo biloba is being investigated as a way to prevent Alzheimer's disease. The National Institute of Aging is funding a research project at the Oregon Health and Science University looking at fish oil as a way to delay the onset of AD. Studies done in the U.S. and in the Netherlands showed a 60–70% decreased risk for AD among a group of elderly who ate at last one serving of fish per week. Should fish oil prove to be effective, consumers would benefit from a low-priced, natural remedy with few known side effects.

A study investigating the use of non-steroidal anti-inflammatory drugs as a preventative measure is underway. The Alzheimer's Disease Anti-Inflammatory Prevention Trial will study the use of naproxin (like Aleve) and celecoxib (Celebrex) in 4,000+ patients with a family history of AD. As these treatments have known side effects, it is difficult to administer such compounds to senior citizens in clinical trials over several years.

Scientists are now exploring methods to help physicians diagnose AD earlier and more accurately. Developing tests that can reveal what is happening in the brain in the early stages of AD will help researchers' understanding of the cause and develop-

ment of the disease. It will also assist in determining how and when to start medications and other forms of treatment so they are most effective. The use of a large gene bank, cell lines, and siblings with late-onset AD is being discussed as a way to help identify at-risk individuals. Advanced neuroimaging technology, such as positron emission imaging (PET) and magnetic resonance imaging (MRI), is being investigated as a way to detect changes in the structure and function of the brain.

Developments in AD research have become fast-paced. Fifteen years ago, we did not know any of the genes that could cause AD. We now know the three major genes for early-onset AD and one of the major risk factor genes for late-onset AD. Fifteen years ago we had no idea of the biological pathways that were involved in the development of brain damage in AD. We now know a lot about the pathways that lead to the development of beta-amyloid plaques in the brain; we don't know if they cause AD or are a byproduct of the disease process.

Major progress has been made in the past 10 years to develop drugs that treat the symptoms of AD. No one knows exactly what causes the disease to begin or why some of the normal changes associated with aging become more extreme and destructive in patients with Alzheimer's. Discoveries from current research are pointing scientists in promising directions and will bring us closer to the day when we will be able to prevent or cure this devastating illness.

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**Darlene M. Jyringi, MPS, is the Program Director for the Alzheimer's Disease Assistance Center of LI, Stony Brook University Hospital, Stony Brook, NY. Ms. Jyringi has developed numerous educational programs for family and professional caregivers, facilitates support groups for caregivers and patients in the early stages of Alzheimer's disease and provides dementia care counseling. She is currently involved in research studies on Alzheimer's disease. She is a Board member of the Aging Long Island Networking Consortium, a member of the Gerontology Professionals of LI, and the Senior Umbrella Network, She has a BA in Anthropology, a Master's degree in Gerontology. She completed additional studies as a Geriatric Scholar, with a specialty in Alzheimer's disease, at Columbia University—New York Geriatric Education Center.**

# Tools for the Caregiver

By Barbara Wolford

Many of us know from our day-to-day interaction with our clients that some of the most difficult, tiresome, frustrating and daunting tasks that burden the caregiver is finding services, resources, agencies and sources of support. Many of our clients have not identified that they are caregivers, but are providing the vast majority of care for their loved one. Many of the caregivers are looking for information, education and training to prepare them for what lies ahead, to be confident in their choices and decisions. Family members want access to professional advice during the transitions and life changes that may loom ahead.

Caregivers face many challenges, as do we the professionals. The questions and answers checklists that follow hopefully will provide the caregiver with suggestions and an overview of some of the issues that they may be facing.

### Fifty Things Every Caregiver Should Know[1]

1. A caregiver is someone who cares for an aging, ill or disabled person.
2. Caregiving duties range from occasional errand-running and other supportive care to 24-hour, live-in support.
3. You don't have to live with the person to be a caregiver.
4. About one-fourth of adults are caregivers.
5. There is no one way to care for a person. Each situation is different.
6. You can provide care yourself or bring in other family members. You can also hire a professional caregiver.
7. The person being cared for may live at home or in your home. Or he or she may live in an assisted living or shared housing situation.
8. Each person being cared for has different needs.
9. When possible, you and the person being cared for should make decisions together.
10. The wishes of the person being cared for are *very important*.
11. Your needs and wishes are important, too.
12. Taking care of yourself is as important as caring for your loved one.
13. Be sure to eat well, get enough rest and exercise regularly.
14. The healthier you are, the better care you will provide!
15. Don't be afraid to say you need a break—no one can do it all of the time.
16. Help and support can come from community organizations, religious organizations, family members, friends or neighbors.
17. When people offer to help, say yes!
18. Keep a list of the things you can use help with, such as bringing dinner or giving you a break. When someone offers to help, have them choose from the list.
19. Find out about meal delivery, transportation services, adult day care and respite care.
20. If you are balancing work and caregiving, talk to your employer about flexibility in your job.
21. You may be able to take time off from work under the Family and Medical Leave Act. This federal law allows qualified employees up to 12 weeks of unpaid time off to care for a family member.
22. A social worker or nurse who assists people in finding care for an older adult is called a care or case manager.
23. A care manager helps find services—whether you live close by or in another city or state.
24. Contact your county social services, local area agency on aging or senior center to find out about care managers, respite care and other services in your area.

25. If the person you are caring for has low or moderate income, you may be able to get financial assistance for care through your county or state.
26. Caregiving duties often change over time. A person may need occasional help now and more care later on.
27. Planning ahead can make caregiving easier in the future.
28. As a caregiver, you will need to learn about medical, financial and legal issues.
29. Talk with the person you are caring for about money, medical care and legal issues. This may not be easy, but it is critical in planning for the future.
30. Keep the person's social security number, doctors' names and phone numbers, prescriptions and insurance information where you can find them in an emergency.
31. Find out about a Health Care Proxy for health care decisions and a Durable Power of Attorney for financial decisions for the person you are providing care for. These give you the legal right to make decisions if your loved one cannot.
32. You may need to know about income, bank accounts, wills and insurance policies.
33. Talk with a lawyer about legal issues and financing care. Legal aid is available to people who cannot afford to pay for a lawyer.
34. Learn as much as you can about the person's illness, disease or condition.
35. Get information about the condition by talking to a health care provider, reading books or searching the Internet.
36. Learning to care for another person can take practice and special skills.
37. Learning how to care for the person can help you feel more confident.
38. You can learn how to provide care from health care professionals, videos or books.
39. All caregivers fell overwhelmed at times. If you feel overwhelmed a lot, you may need to get help.
40. If you feel angry or often lose patience with the person you are caring for, get help.
41. If you use alcohol, drugs or medications in order to cope, get help.
42. If you are depressed, talk to a doctor, counselor or therapist. Depression can be treated.
43. It is critical for caregivers to develop a support system.
44. You can get support from a support group, therapist, family members or friends.
45. One of the best resources for caregivers is other caregivers.
46. Caregiver support groups can help you connect with others who are going through similar experiences.
47. A sense of humor can help you deal with the emotional ups and downs.
48. Caregivers who get help are less likely to burn out.
49. Caregivers who get help are better able to provide care for the long term.
50. Caregiving is not an easy job—but it can be very rewarding.

As professionals, we can help our clients who are overwhelmed by caregiving and share some of the burden, to listen, to empathize and make a difference in their lives.

### Endnote

1. From Richmond, 50 Things Every Caregiver Should Know (Journeyworks Publishing 2003).

**Barbara Wolford is the Director of Elder Care Services for the elder law and estate planning firm of Davidow, Davidow, Siegel & Stern. She has been associated with the firm since 1996. Ms. Wolford is a Licensed Practical Nurse who concentrates in assisting families with the complex Medicaid process as well as the assessment procedure necessary for evaluating families' needs. Her background as a former Nursing Home Admissions Director lends itself well to her current position. In addition, she is very active in senior organizations and advocacy by serving as the co-director of the Council for the Suffolk Senior Umbrella Network, a board member of the New York State Coalition for the Aging, a member of the Long Island Coalition for the Aging, a member of the American Association on Aging, Nassau and Suffolk Geriatric Professionals of Long Island and Case Management Society of America.**

# Seven Defensive Will Drafting Tips for the Elder Law and Trust and Estates Practitioner

By Anthony J. Enea

With the disintegration of the nuclear family and the "baby boomers" coming of age, it is inevitable that the number of Will contests filed will significantly increase in the future. Having taken numerous depositions in Will contests, I can assure you that the attorney-draftsperson of a Last Will will find him or herself on the front lines of the Will contest. In order to avoid a successful challenge to a Last Will and preserve the integrity of the Last Will you have prepared, there are, in my opinion, seven (7) steps which should be undertaken without fail:

**1. Determine Who Your Client Is**—Often family members and friends will schedule and accompany a senior to the initial consultation with an attorney. Thus, during the initial consultation, individuals other than the person for whom you are preparing a Last Will, often interject their views and comments.

This creates difficulties for the attorney who needs to insure that the client is acting free of any undue influence and/or fraud. During the initial consultation, I attempt to make it clear to all in attendance that the individual I will be representing is the individual for whom I will be drafting the Last Will, Trust and/or any other documents. If, during the consultation, there is any discussion of the client not making any provision for one or more children, or any other distributee of his or her estate, I ask to speak with the client alone to ascertain the reasons for his or her decision, and to determine that said decision is being freely made.

**2. Obtain Biographical, Filial, Medical and Financial Information**—Obtaining as much information about the client and his or her family is critical to being able to defeat a Will contest. All too often many attorneys are reluctant to pry into the private affairs of clients. More than once I have had the occasion to question an attorney-draftsperson who testified that he or she did not ask the client about the details of the client's finances, because he or she felt it was a private matter. This reluctance to make inquiry could prove to be disastrous if the Will is challenged. One of the necessary inquiries an attorney should make for purposes of establishing testamentary capacity is whether or not the Testator knows and understands the nature, extent and objects of his/her bounty. The attorney should always endeavor to obtain a complete financial portrait of the client.

Obtaining all of the aforestated information, whether through the use of a questionnaire or the direct questioning of the client, with copious notetaking, will provide the attorney with a complete portrait of the client. This paper portrait is often the first line of defense to a Will contest, and an invaluable asset to the attorney at his or her deposition.

Inquiring about the client's medical conditions will also alert you as to whether the client is suffering from any illnesses, or taking any medications, that could affect his or her reasoning or judgment. This often acts as a red flag to the attorney that it may be prudent to obtain the opinion or statement from a physician that the client has the requisite capacity to execute a Last Will.

**3. Take Thorough Notes About the Clients' Testamentary Wishes**—Document exactly what the client stated about his or her testamentary wishes. If, for some reason, the client articulated why he or she wanted Cousin Johnny to get twenty-five percent of his or her estate, you should make note of it. The statements of the client become particularly important if the client has decided to exclude a child or a distributee from his or her testamentary plans.

The ability of the client to articulate logical and cogent reasons for his or her testamentary wishes, and your notes relevant thereto, will go a long way in helping to defeat a Will contest. Counsel should thoroughly review with the client all testamentary dispositions and the names and addresses of all beneficiaries to be named, as well as any alternates.

**4. Mail a Draft of the Last Will to the Client**—Many attorneys find it more convenient and less time-consuming to prepare the Last Will, and once it is prepared, to schedule an appointment for its execution. I believe it is a much more prudent procedure

to mail the client a proposed draft of the Last Will, and allow the client the opportunity to review the Last Will without the time constraints of a scheduled appointment.

This procedure helps to ensure that the client is given an adequate amount of time to review the Last Will and any other documents. This is especially helpful when the client is a senior who may be accompanied by family members to any appointment.

**5. Meet With the Client Alone to Review Terms of Last Will Prior to Its Execution**—As a matter of practice immediately prior to the Will signing, the attorney should meet with the client alone to review the terms of the Will and any other documents to be signed, such as a health care proxy and durable power of attorney. This meeting will again allow the attorney an opportunity to assess the testamentary capacity of the client, and to determine that the client is acting free of any undue influence or fraud. All too often I have had the occasion to hear testimony from an attorney that he or she reviewed the Last Will in the presence of the beneficiary who is accused of having asserted undue influence.

Additionally, by meeting with the client again, the attorney has another contact with the client that he or she will be able to document. If any modifications are made by the client to the Last Will, they should also be noted by the attorney.

**6. Follow Consistently Identical Will Execution Procedures**—Unless you have an exceptional memory, it is highly unlikely that years later you will be able to recall and testify about the specifics of a particular Will execution ceremony and the client. It is also highly unlikely that the attesting witness will have the ability to recall any specifics. However, if the attorney consistently follows the same procedures, the attesting witnesses and the attorney will be more likely to be able to recall, and testify as to, the procedures followed.

For example, you may want to adhere to procedures similar to the following practice which will satisfy all of the requirements for the due execution of a Will pursuant to EPTL § 3-2.1.:

(a) Clear the writing surface of all documents other than the Last Will and other documents to be executed;

(b) Introduce Testator to witnesses and make some conversation to allow witnesses to observe Testator's capacity. You may also wish to have the Testator read a portion of the Will or another document;

(c) In the presence of the witnesses make the following inquiries of the Testator:

1. Have you read this document?;
2. Is this document your Last Will and Testament?;
3. Does this document dispose of your assets and worldly possessions in accordance with your wishes?;
4. Is anyone forcing you to sign this document?;
5. Would you like the others and me to act as witnesses to your Last Will?

*"I believe it is a much more prudent procedure to mail the client a proposed draft of the Last Will, and allow the client the opportunity to review the Last Will without the time constraints of a scheduled appointment."*

While some attorneys prefer not to act as witnesses and have two other witnesses, I prefer to act as a witness and have one additional witness. I believe that limiting the witnesses to one individual other than myself will help reduce the potential of conflicting testimony;

(d) Once the Testator has appropriately responded to all of the above stated inquiries, have the Testator initial each page and sign and date the Last Will at the end thereof in the presence of all of the attesting witnesses;

(e) Read the attestation clause aloud and have the witnesses sign on the same page as the Testator beneath the attestation clause, and also have the witnesses sign a self-proving affidavit, all of which should be signed by the witnesses in the presence of each other. Not having a self-proving affidavit attached to the Will only further complicates having the Will admitted to Probate.

In recent years many attorneys have opted to video or audiotape the Will execution ceremony. While in many cases the audiotape or videotape could deal a devastating blow to any attempted challenge, when dealing with an elderly or frail client the

use of such a recording may only serve to magnify those frailties.

**7. Take Steps to Ensure that the Last Will Is Properly Assembled and Stapled**—The attorney should review the signed Last Will in its entirety to ensure that all pages have been initialed, that the Testator and witnesses have signed on the appropriate lines, and that it is assembled in proper order.

Recently, I had the occasion to review a Last Will which only had a month and year stated, but no specific date. Additionally, the self-proving affidavit of said Will was dated on a month, day and year different from the Last Will. Obviously, these were typographical errors, but this kind of sloppiness can only lead to problems.

Although it may seem cynical, if you treat each Last Will and its execution as a potential Will contest, and take defensive steps to ensure the integrity of the Will, you should be able to defeat any Will contest, and avoid having to give embarrassing testimony at a deposition. It is important to remember that the most successful Will challenges result because of the existence of numerous bits and pieces of circumstantial evidence. The attorney-draftsperson of the Will should endeavor to avoid being one of those bits and pieces.

**Anthony J. Enea is a member of the law firm of Enea, Scanlan & Sirignano, LLP of 245 Main Street, White Plains, New York, (914) 948-1500. His office is centrally located in White Plains, and he has a home office in Somers, New York.**

**Mr. Enea is certified as an Elder Law Attorney by the National Elder Law Foundation as accredited by the American Bar Association.* Since 1992, he has been the Chair of the Elder Law Committee to the Westchester County Bar Association. He is a member of the Executive Committee of the Elder Law Section of the New York State Bar Association as Vice Chair of the Guardianship and Fiduciary Committee and a member of the National Academy of Elder Law Attorneys. Mr. Enea is the Vice President of the Westchester County Bar Association and is fluent in Italian.**

*The National Elder Law Foundation is not affiliated with any governmental authority. Certification is not a requirement for the practice of law in the state of New York and does not necessarily indicate greater competence than other attorneys experienced in this field of law.

# Intergenerational Strategies for the Future

By Paul Arfin

A tremendous generational divide is rapidly forming in many parts of the nation. This divide will cause economic and social problems unless it is addressed.

Our population is aging rapidly while our younger population is declining. One implication of these demographic realities is that the number of people in the traditional working years (18–65) may not be sufficient in number to pay the taxes for the rising costs of caring for a growing dependent population. How will they pay for invaluable governmental programs such as Social Security, Medicare, and Medicaid as the pool of young workers declines and the number of older adults who have left the labor pool increases?

On the social side, we are growing apart, what with the boom in age-segregated, senior retirement communities, senior housing, and assisted living quarters. Children and older adults need one another. Elders pass on traditions and wisdom to the young. The young transmit hope and enthusiasm to the older. They need to be together. If we don't provide more intergenerational housing developments, we will continue to segregate young and older.

So what's to be done? Part of the solution lies with public leadership and civic activism. We need more elected officials, governors, mayors, town supervisors, and town councilmen and women to put their jobs on the line to advocate for changes to our zoning ordinances. We need our civic associations to use their influence to sway local politicians about these economic and social conditions just like they do when they want a traffic light, increased police protection, or rehabilitation of a blighted area. We need our rotary clubs, chambers of commerce, and churches to join the campaign for affordable intergenerational housing.

We can also create home-sharing programs where older homeowners needing either companionship or practical help receive the help they need in exchange for providing affordable living space to well-screened, reliable, low-income individuals. Such programs operate throughout the world. They use existing housing stock more efficiently and could reduce the need to construct new housing units.

Age stereotyping results from a lack of ongoing contact among the generations. Our public and private schools should establish aging education curricula to expand children's understanding of the life cycle and their appreciation for the wonders of older adulthood and the opportunities for creativity and freedom that it offers. Schools, religious organizations, and libraries need to create programs that foster intergenerational communications.

*"If we don't provide more intergenerational housing developments, we will continue to segregate young and older."*

And last but not least, we should create new opportunities for older adults to get involved in public service. This rapidly growing group possesses time and talent that can benefit all of us. Their knowledge and life experiences could be invaluable in addressing some of our social ills by advocating for changes needed in our public policies. In addition, too many of our service organizations are begging for volunteers to help them serve their communities.

We have a responsibility to future generations to address these issues and challenges. Let us move forward to think and act intergenerationally. By so doing, we can assure a better life for generations to come.

**Paul Arfin is President/CEO of Intergenerational Strategies, a Long Island, New York-based non-profit organization that advocates for sensible intergenerational policies and programs.**

## NYSBA ELDER LAW SECTION LEADERSHIP TASK FORCE

Under the leadership of our Chair, Howie Krooks, a Leadership Task Force has been formed. The purpose of the Task Force is to review the Section's current approach to leadership in the Elder Law Section. In order for the Section to remain strong and stable, it is of the utmost importance that the Section identify, encourage and foster new leadership.

Committee members are: Cora A. Alsante, Michael Amoruso, Daniel G. Fish, Bernard A. Krooks, and Kathryn G. Madigan.

We are actively seeking your comments and questions. Please feel free to contact me (at vincent@russoelderlaw.com) or any member of the Task Force.

We look forward to hearing from you.

Vincent J. Russo
Chair, Leadership Task Force

# New York Case News

By Judith B. Raskin

## Medicaid

**DSS appealed from a determination that a spouse's remainder interest in real property was not an available asset for purposes of Medicaid reimbursement. Reversed. *Commissioner of DSS v. Morello, Jr.*, N.Y.L.J., June 24, 2004, p. 25, col. 5 (A.D. 1st Dep't).**

Respondent had a remainder interest in his father's real property and his wife was a Medicaid recipient. DSS took the position that the remainder interest was an available resource. The respondent argued that the remainder interest could not be sold and therefore had no value. After a non-jury trial and summary judgment motions by both parties, the Supreme Court, New York County denied, *inter alia*, DSS' summary judgment motion, holding that the remainder interest was not an available resource for Medicaid reimbursement. Based upon an attorney's affidavit, the court determined that there was no market for the remainder interest and therefore it had no value. DSS appealed.

The Appellate Division reversed, granting the summary judgment motion by DSS. The court found that the remainder interest was an available resource. The court determined the value of the remainder interest to be the undisputed market value of the real property set forth on the Medicaid application multiplied by the applicable percentage on the Life Interest and Remainder Table published by the Federal Health Care Financing Administration. The dissent by two justices agreed with the determination that the remainder interest is an available resource but would remand for a hearing to determine the value.

## Health Care Proxy

**Petitioner sought an order requiring defendant hospital to release medical records of patient to petitioner as health care proxy. Granted. *Mougiannis v. North Shore-LIJ Health System, Inc.*, N.Y.L.J., May 19, 2004, p. 19, col. 3 (Sup. Ct., Nassau Co.).**

Petitioner was attorney in fact and health care proxy for her mother who was hospitalized for decubiti and a fractured hip. As her mother was unable to make her own medical decisions, petitioner was acting as health care agent. During the hospital stay, the defendant hospital denied petitioner access to her mother's medical records and did not keep petitioner informed of her mother's medical condition, which had deteriorated. After her mother's discharge, petitioner requested all medical records for the period of her mother's hospital stay but the hospital told her she was not entitled to the records after discharge.

Petitioner moved for an order, *inter alia*, requiring defendant to preserve and/or provide the complete medical records for the time of her mother's stay at defendant hospital. Defendant moved to dismiss as a matter of law as the petitioner is not a "qualified person" entitled to the records. The hospital cited New York PHL § 18(1)(g), which defines a qualified person as ". . . any properly identified subject, or a guardian appointed pursuant to article eighty-one of the mental hygiene law, or a parent of an infant, or a guardian of an infant appointed pursuant to article seventeen of the surrogate's court procedure act or any other legally appointed guardian of an infant who may be entitled to request access to a clinical record pursuant to paragraph (c) of subdivision two of this section, or an attorney representing or acting on behalf of the subject or the subject's estate." This definition does not include a health care proxy. The hospital also argues that HIPAA's privacy regulations dictate maintaining the privacy of confidential records.

The court held that as health care proxy, the petitioner was entitled to the medical records. While HIPAA is not specific about the right of a health care proxy to confidential medical records, Public Health Law § 2982(3) states: "Notwithstanding any law to the contrary, the agent shall have the right to receive medical information and medical and clinical records necessary to make informed decisions regarding the principal's health." Based on this language, the court holds a health care proxy to be a qualified person under the New York PHL. The court advised that although this language is stated in the Public Health Law, it is advisable to include in the health care proxy the authority of the agent to receive medical information under HIPAA.

The court also found that the hospital did not comply with PHL § 18, which required the hospital to respond to the petitioner's request for medical records in writing and inform her of her appeal rights.

## Trusts

**Petitioners sought reformation of pre-Escher irrevocable trusts to incorporate supplemental needs trust provisions. Denied. *In re Rubin* and *In re Mortimer*, N.Y.L.J., June 15, 2004, p. 24, col. 5 (Surr. Ct., New York Co.).**

Two applications were decided together. In both cases, the applications requested that irrevocable trusts created prior to the decision in *In re Escher* be reformed to conform to the requirements of a supplemental needs trust. The objective was to make the trust funds unavailable to the disabled beneficiaries so that they could apply for government entitlements while protecting the trust principal for the remaindermen.

The court denied the request for reformation in each instance. Reformation is mainly to correct mistakes or to reflect the settlor's actual intent, not to change the terms to what the settlor would have provided if the settlor foresaw future changes in law or circumstance.

## Article 81

**An attorney appealed from a decision in an Article 81 proceeding *inter alia* denying him legal fees where he was guardian and served as attorney for the guardian. Reversed in part. *Application for Appointment of Guardian of Ava Leventhal*, N.Y.L.J., June 17, 2004, p. 27, col. 5 (A.D., 1st Dep't).**

Petitioner and co-guardian was denied legal fees for legal services he performed as attorney for himself as a co-guardian.

On appeal, the court reversed that part of the decision denying legal fees where the guardian was unable to find an attorney to handle a matter on a contingency basis because of the small likelihood of success. The court cited the relatively new regulation at 22 N.Y.C.R.R. 36.2(c)(8), effective June 1, 2003, that a guardian may not appoint himself as attorney "unless there is a compelling reason to do so." In reversing the decision in part, the court found that the guardian/attorney did provide exceptional services to the incapacitated person resulting in a reinstatement of the person's nursing home insurance. The fact that another attorney would not handle the matter on a contingency basis constituted a unique circumstance.

**Is a contract presumptively void if entered into by a person deemed to be an incapacitated person (IP) in an Article 81 proceeding? A contract entered into by an IP is voidable but not presumptively void. *In re Diaz*, N.Y.L.J. July 6, 2004, p. 21, col. 1 (Sup. Ct., Queens Co.).**

Dennis Diaz, 28 years old and suffering from cerebral palsy, was deemed an incapacitated person in an Article 81 proceeding in October 2001. His mother was appointed guardian for his personal needs and the court appointed an attorney for property management. However, circumstances were such that the guardian of the property could not be bonded and so Mr. Diaz did not have a guardian for a period of time during which Mr. Diaz executed a contract to purchase a tavern for $15,000 with settlement proceeds and then entered into a lease agreement with the landlord to operate the tavern on the premises. Mr. Diaz was represented by competent counsel and set up a corporation to assume ownership of the tavern. The court examiner brought this contract to the court's attention in January 2003. No information was presented to show any profits or losses from the venture.

The court determined that the contract was not presumptively void but was voidable. The court voided the lease, and allowed the seller, who did not know that Mr. Diaz was incapacitated, to keep the purchase price, and gave Mr. Diaz possession of all contents of the tavern subject to creditors of the corporation.

Prior to the enactment of Article 81, contracts entered into by persons deemed incompetent were presumptively void. Under Article 81, Mr. Diaz was deemed an incapacitated person and therefore, his contract is not presumptively void but is voidable. If the court found that Mr. Diaz was incapacitated at the time of entering into the contract, the court could void the contract. The court found that Mr. Diaz was adequately represented by counsel and the guardian never moved to rescind the contract.

**Judith B. Raskin is a member of the law firm of Raskin & Makofsky, a firm devoted to providing competent and caring legal services in the areas of elder law, trusts and estates, and estate administration.**

**Judy Raskin maintains membership in the National Academy of Elder Law Attorneys, Inc.; the New York State Bar Association, where she is a member of the Elder Law and Trusts and Estates Law Sections; and the Nassau County Bar Association, where she is a member of the Elder Law, Social Services and Health Advocacy Committee, the Surrogate's Trusts and Estates Committee and the Tax Committee.**

**Ms. Raskin shares her knowledge with community groups and professional organizations. She has appeared on radio and television and served as a workshop leader and lecturer for the Elder Law Section of the New York State Bar Association as well as for numerous other professional and community groups. Ms. Raskin writes a regular column for the *Elder Law Attorney*, the newsletter of the Elder Law Section of the New York State Bar Association, and is a member of the Legal Committee of the Alzheimer's Association, Long Island Chapter. She is past president of Gerontology Professionals of Long Island, Nassau Chapter.**

# Legislative News

By Howard S. Krooks and Steven H. Stern

Howard S. Krooks

## New York State Budget Bill

On August 11, 2004, the New York State legislature finally enacted the budget (after the longest delay in history). The legislature rejected the Governor's proposed 2004-2005 changes to Medicaid eligibility for long-term care. As practitioners know, these proposed changes included such provisions as extending the look-back period to 60 months, imposing an ineligibility period for community Medicaid services caused by the transfer of assets, eliminating spousal refusal in home care cases and commencing the penalty period for Medicaid services on the date of application rather than on the date of the gift. The New York State Bar Association, the Elder Law Section, and many other consumer groups must be commended for their tremendous advocacy efforts on behalf of New York's elderly and disabled population.

Although the Governor's Medicaid-related proposals failed, the legislature did adopt many new provisions regarding long-term care insurance, primarily to encourage the purchase of long-term care policies. These include the development of a long-term care insurance education and outreach program with resource centers throughout the state to provide direct assistance to the public in obtaining long-term care insurance. Specifically, the budget bill included the following provisions:

- an increased tax credit for the insurance premium paid to 20% (up from 10%).
- a provision which creates portability of the Medicaid portion of a New York State Partnership policy. This means that each of the other states (presently California, Connecticut and Indiana) that offers a Partnership program would agree to recognize the Medicaid coverage part of the policy with each other.
- the establishment of Long-Term Care Insurance Resource Centers within local area aging agencies as an outreach program to educate the public about long-term care insurance.
- the ability of policyholders to designate a third party to receive notice of nonpayment or cancellation in order to prevent a policy lapse.
- a directive to New York State agencies to study alternative methods of financing long-term care

Steven H. Stern

Despite the success in defeating the Governor's proposals, it is all but certain that the Governor and the legislature will propose the Medicaid-eligibility-related changes in next year's budget.

## Assisted Living Bill

The "Assisted Living Reform Act" was passed on August 12, 2004 (S. 7748). It amends the Public Health Law, Social Services Law and the state Finance Law and is the first of its kind to address licensing and disclosure requirements of assisted living facilities. All residences that operate or provide services as an assisted living residence as outlined by the Act will be required to apply for the necessary approvals, certifications and licenses within 60 days of the effective date. The failure to due so will result in criminal (Class A misdemeanor) and civil penalties.

*"The New York State Bar Association, the Elder Law Section, and many other consumer groups must be commended for their tremendous advocacy efforts on behalf of New York's elderly and disabled population."*

The Act expands the definition of an adult home in subdivision 25 of section 2 of the Social Services Law, and also adds an additional section concerning the funds allocated to carry out the Act, including appointment of a Task Force to section 4 of the state Finance Law at 99-1.

Article 46-B is intended to create a clear and flexible statutory structure for assisted living. It outlines three types of assisted living scenarios for residences and details the separate requirements for licensure by the state for each scenario. The scenarios are: assisted living, enhanced assisted living, and assisted living for those with special needs. The article defines

assisted living and assisted living residences as separate from adult homes. Only a residence currently licensed as an adult home can become licensed as an assisted living residence, and only an assisted living residence can become licensed as an enhanced assisted living residence and/or a residence approved to provide special needs.

*An assisted living residence* is an entity that provides or arranges for housing, on-site monitoring, personal care services and/or home care services (either directly or indirectly) for a home-like setting to five or more adult residents unrelated to the assisted living provider. Also, the facility must include daily food service, 24-hour on-site monitoring, care management services and the development of and continual update of an individualized service plan ("ISP") for each resident. The ISP is developed in consultation with the resident, the resident's adviser and, if applicable, the home health care provider. All services must be provided in the least restrictive and most home-like setting commensurate with the resident's preferences and physical and mental status.

If the residence intends to accommodate those that need a larger degree of the above services (for example, those that chronically require physical assistance to walk, use stairs or have unmanageable urinary or bowel incontinence), then the residence must apply for and become licensed as an *"enhanced" assisted living residence*. If the residence plans to accommodate those with *special needs*, which include those persons with dementia and/or cognitive impairment, then the residence must apply for and become permitted to provide for those needs.

The requirements for licensure at a base level are the same, but then vary depending on the degree of care that is provided. All of the applications include extensive disclosure concerning the residence, its owners, staff and financing arrangements, the residents they will admit, intended services and how they will be accomplished (staff, education, equipment, licenses). Each residence is further required to supply a detailed Residency Agreement, updated as necessary. This is a document in 12-pt. font, plain language, signed and dated by all parties and includes over 16 items to disclose as per the article. This includes extensive disclosures (as mentioned above), term, admission and termination information, licenses and statuses, description of services and additional services, providers and the prices for services, billing, and rights and responsibilities.

Other notable items created by the Act are the Resident Bill of Rights; development of a Consumer Information Guide; powers granted to the Commissioner to make rules and regulations for the article, receive and investigate complaints, conduct investigations and issue fines and penalties; and the creation of a Task Force. The Task Force's stated goal is to increase and ensure affordable health care, individualized choice, autonomy and independence of those in or in need of assisted living.

**Howard S. Krooks is a partner in the law firm of Littman Krooks LLP, with offices in New York City and White Plains. Mr. Krooks is certified as an elder law attorney by the National Elder Law Foundation and is Chair-Elect of the Elder Law Section of the New York State Bar Association. Mr. Krooks co-authored a chapter ("Creative Advocacy in Guardianship Settings: Medicaid and Estate Planning, including Transfer of Assets, Supplemental Needs Trusts and Protection of Disabled Family Members") included in *Guardianship Practice in New York State*, a book published by the New York State Bar Association. Mr. Krooks has lectured frequently on a variety of elder law topics for the National Academy of Elder Law Attorneys, the National Guardianship Association and the New York State Bar Association. In addition, Mr. Krooks has served as an instructor for the Certified Guardian & Court Evaluator Training: Article 81 of the Mental Hygiene Law Program sponsored by the Association of the Bar of the City of New York.**

**Steven H. Stern is a partner in the law firm of Davidow, Davidow, Siegel and Stern, LLP, with offices in Islandia and Melville, Long Island. Founded in 1913, the firm concentrates solely in the practice areas of elder law, business and estate planning. Mr. Stern is a member of the National Academy of Elder Law Attorneys and is the current Co-Chairman of the Suffolk County Bar Association's Elder Law Committee. He also serves as a member of the Suffolk County Elder Abuse Task Force's Consultation Team. With a strong commitment to educating the local senior community, he is a frequent speaker and published author and also hosts "Seniors Turn to Stern," a radio program on WLUX dedicated to the interests of seniors and their families.**

# Practice News

## A Tax Primer on Irrevocable Trusts
### (Established for Medicaid Asset Protection)

By Vincent J. Russo

**A. Why Irrevocable Living Trusts?**

When implementing an asset protection plan for seniors, an Irrevocable Living Trust should be considered. I refer to this type of trust as an "Asset Protection Trust" in my practice. Some practitioners call this type of trust a "Medicaid Trust" or an "Irrevocable Income Only Trust." It is absolutely critical that the trust meet the requirements under OBRA 1993 in order to have the assets in the trust excluded for purposes of Medicaid eligibility. At the same time, it is also very important to understand the tax treatment of this type of trust. Under the Internal Revenue Code, an Irrevocable Living Trust is a trust established during the Grantor's lifetime in respect of which the Grantor has no power to revoke or amend. The elder law attorney has the ability to impact upon the income, gift and estate tax consequences of this type of trust depending upon how it is drafted.

For purposes of this article and in my practice as well, my Irrevocable Living Trust typically is usually a "Grantor Trust" for income tax purposes. The trust is funded with assets that are treated as an incomplete gift for gift tax purposes. The trust assets are included in the estate of the Settlor upon his demise.[1]

**B. How are Irrevocable Trusts Treated For Income Tax Purposes**

1. *Income Taxation—Overview*. A trust can be either a separate taxable entity or a conduit through which income is passed to the beneficiaries.

   Income generated by the trust assets is taxable to the trust, the Grantor or other beneficiaries of the trust, depending upon how the trust has been structured. (Code Section 671).[2] The theory is that either the trust or the beneficiary, but not both, should be taxed on the income. The "flow through" of income (and its character) from a trust to a beneficiary is sometimes referred to as the "Conduit Theory" of Subchapter J of the Internal Revenue Code.

   (a) *Income Taxable to Trust.* Income is taxable to the trust if it is accumulated by the trust.

   (b) *Income Taxable to Beneficiaries.* Income is generally taxable to the beneficiaries to the extent that the trust actually distributes the income to them or makes it available to them.

   (c) *Income Taxable to Grantor.* The Grantor may be taxed on trust income in accordance with any of the Grantor trust rules of Code Sections 671–677. The rationale is that the Grantor is considered the owner of all or a portion of the trust and thus must pay tax on the trust's income. *See*, *e.g.*, Code Section 673(a).

   (d) *Distributable Net Income "DNI."* DNI, a term which exists only in the context of trust and estate income taxation, allocates income tax liability between a trust and a trust beneficiary (Code Section 643(a)). DNI is used to compute a trust's income tax deduction for amounts distributed to the beneficiaries. DNI is also used to quantify the amount that a beneficiary needs to report as income from the trust.

2. *Tax Treatment by Code Section*. There are various Code Sections that must be reviewed in order to determine "Grantor Trust" status.

   (a) Code Section 673 (Reversionary Interests) taxes the income to the Grantor if he or she retains a reversionary interest in either trust principal or income with a present value of more than 5% of the value of the trust.

   (b) Code Section 674(a) (Power to Control Beneficial Enjoyment) taxes the income to the Grantor if he or she retains the right to control the beneficial enjoyment of the trust property or its income.

   (c) Power to Remove and Replace Trustee (Treas. Regs. Section 1.674(d)-2) provides that if the Grantor holds an unrestricted power to remove, substitute, or add

trustees and to designate any person including himself or herself as the replacement trustee, the trustees' powers are deemed to be exercisable by the Grantor for purposes of determining Grantor trust status.

(d) There are eight exceptions under Code Section 674(b) which do not result in income taxation to the Grantor. For example, a Grantor is not taxed on a trust containing an unexercised power to apply income to the support of a dependent.

(e) Code Section 675 (Administrative Powers) taxes the income to the Grantor if he or she retains possession of certain administrative powers.

(f) Under Code Section 675, actions taken by the Grantor or non-adverse party without the approval of an adverse party will result in the Grantor being taxed on the trust income. These actions include the power enabling anyone to dispose of income or principal for less than full value (Code Section 675(1)) or the power enabling the Grantor to borrow without adequate interest or security (Code Section 675(2)). However, if the Trustee may lend to anyone without adequate security, the fact that the Grantor is included among the trust's permissible borrowers does *not* cause the Grantor to be taxed on the trust's income. (Code Section 675(2)).

(g) Borrowing of Trust Funds. If the Grantor has directly or indirectly borrowed the corpus or income and has not completely repaid the loan, then the Grantor will be taxed on the trust income. (Code Section 675(3)).

(h) General Powers of Administration, include (a) power to vote or direct the voting of stock, (b) power to control the investment of trust funds, or (c) power in a non-fiduciary capacity to reacquire trust corpus by substituting other property of equal value. (*See* Code Section 675(4)).

(i) Code Section 676 (Power to Revoke) does not apply to irrevocable trusts, since it deals only with revocable trusts.

(j) Code Section 677 (Income for Benefit of Grantor) taxes the income to the Grantor if trust income is or may be payable to or for the benefit of the Grantor or his or her spouse, accumulated for them, or applied to the payment of premiums on insurance on the lives of the Grantor or his or her spouse.

(k) Code Section 677(b) carves out an exception to 677(a) relative to income for the support of a legal dependent of the Grantor, imposing liability on the Grantor only if the income is *actually* used for support, not merely if it *may* be used.

3. *Trustee's Role—Income Taxation Issues*. The identity of the trustee may affect the income tax consequences of the trust.

(a) Non-Adverse Party. Under Code Sections 674 and 677, a power exercisable by a non-adverse party is treated the same as if such power were exercisable by the Grantor.

A non-adverse party is any person who does not have a substantial beneficial interest which would be adversely affected by the exercise or non-exercise of that power which he or she possesses.

(b) *Tax Planning Note*. The trust can be set up so that part of the income is taxable to the trust and part to the beneficiaries. It is typical in my practice to have all of the trust income taxable to the Settlor (the senior), regardless as to whether I have drafted the trust for the senior to receive the income on a mandatory basis, a discretionary basis or not at all. If the income is not mandated to the Settlor and Grantor Trust status is desired, in my practice the trust provides for a power to remove and replace the trustee (other than the Grantor or Grantor's spouse). This can be helpful when the Grantor is in a lower income tax bracket than other beneficiaries named in the trust (Code Section 671-677). If this result is desired, it is essential to have the trust treated as a Grantor Trust under the Grantor Trust rules.[3]

### C. Gift Tax Consequences on the Funding of the Trust

1. *Overview*. Upon funding of the trust, there may be a transfer of assets for gift tax purposes, depending upon the terms of the trust (Code Section 2501).

2. *Medicaid Planning Note*. The transfer to an Irrevocable Trust or to a third party from an

Irrevocable Trust will trigger a transfer subject to the Medicaid transfer rules. The look-back period is 60 months. If there is no penalty on funding, then transfers from the trust to a third party may be subject to only a 36-month look-back period.

3. *Completed Gift*. Once Grantor has parted with dominion and control over the property so that the Grantor cannot change its disposition, the gift is deemed completed (Treas. Regs. Section 25.2511-2(b)).

4. *Incomplete Gift*. A gift is incomplete in every instance in which donor reserves the power to re-vest the beneficial title to the property to himself or herself. A gift is also incomplete if and to the extent that a reserved power to name new beneficiaries or to change the interests of the beneficiaries as between themselves, unless the power is a fiduciary power limited by a fixed or ascertainable standard. (Treas. Regs. 25.2511-2(c)).

   If the Grantor retains a power over the disposition of the trust assets, such as a testamentary power of appointment over the remainder upon death, then no portion of the transfer is considered a completed gift. (Treas. Regs. Section 25.2511-2(c)). Therefore, gift taxes can be avoided upon funding of such a trust or at the time a revocable trust becomes irrevocable.

5. *Medicaid Planning Note*. From a Medicaid eligibility context, the Testamentary Power of Appointment should be limited to a class of beneficiaries, excluding the Grantor, Grantor's estate and creditors of the Grantor or Grantor's estate. If Medicaid planning is being implemented for the spouse as well, then the spouse, spouse's estate and creditors of the spouse or spouse's estate should be excluded. In my practice, this is the provision that I use to render the funding of the trust as an incomplete gift.[4]

6. *Tax Planning Issue*. If the Grantor is physically or mentally incapable of exercising the limited power of appointment, will "possession" of the limited power cause the funding of the trust to be an incomplete gift? Case law and an IRS Revenue Ruling have taken the viewpoint that the mere possession at death of the power, rather than the exercise of, or inability to exercise the power is the determinative criterion. *See* Revenue Ruling 55-518, 1955, 12 C.B. 384; *Boeving v. U.S.*, 493 F. Supp. 665 (D. Mo. 1980), *rev'd*, 650 F.2d 493 (8th Cir. 1981), *Alperstein*, 613 F.2d 1213 (2d Cir. 1979), *cert. denied*, 446 U.S. 981 (1980).

7. *Partial Gift*. If the Grantor retains a partial interest such as a life estate, then only the remainder interest will be considered a completed gift. The Revenue Act of 1990 added Code Sections 2701–2704 to govern the valuation of transfers of interests in closely held corporations, partnerships and trusts to a family member. For our purposes, the transfer of real property with a retained life estate to an Asset Protection Trust will be treated as a gift of the entire value of the real property.

8. *Tax/Medicaid Planning Note*. The gift to the trust may qualify for the $11,000 annual exclusion, as long as the present interest requirement is satisfied. Methods of satisfying this requirement are: (i) providing for "Withdrawal Powers," sometimes referred to as "Crummey Powers" in the trust; or (ii) mandating the distribution of income, at least annually. This may be problematic if the trust is for asset and income protection in the context of government benefits, such as Medicaid.

9. *Tax Planning Note*. The gift may qualify for the marital deduction if the requirements of Code Section 2056 are met. This may be relevant where the well spouse is funding a trust that will allow the married couple to treat the gift as deductible for gift tax purposes. The trust assets will be included in the estate of the ill spouse offset by his or her unified credit exclusion. This would be a way to implement tax planning and Medicaid planning at the same time.

### D. Gift Tax Consequences on Distributions From The Trust

1. *Non-Taxable*. If the transfers funding the trust were classified as "completed gifts" subject to gift tax, then the distributions from the trust are not "gifts" subject to gift tax.

2. *Taxable*. If the transfers funding the trust were classified as "non-completed gifts" and hence not subject to gift tax, then the distributions from the trust to individuals other than the Grantor are taxable "gifts" (Treas. Regs. Section 25.2511-2(f)). This would typically be the case in an Asset Protection Trust. For Medicaid purposes, the distributions would not be subject to the Medicaid penalty rules since the Grantor gave up all ownership and control of the assets under OBRA 1993.[5]

### E. Estate Taxation of the Trust Assets Upon Demise of the Settlor

1. *Included in the Estate*. If the gift is incomplete or if the Grantor has retained powers over the transferred property under Code Sections 2035–2038, such property will be included in the Grantor's estate at death.

   For example, if the Grantor is the recipient of some part or all of the trust income and/or principal, the trust principal will be fully included in the Grantor's gross estate for estate tax purposes because the Grantor has reserved an income interest from the trust created by the Grantor (Code Sections 2036, 2037 and 2038).

2. *Step Up in Basis*. Under current tax law if the trust property is included in the Grantor's estate, then the beneficiaries will receive the property with a step up in basis to the fair market value of the property on the decedent's date of death (Code Section 1014(a)(1)) or the alternative valuation date under Code Section 2032 (Code Section 1014((a)(2)).[6]

3. *Tax Planning Note*. In my typical Asset Protection Trust, I would provide for either mandatory income to the Grantor or reserve a limited power of appointment which results in the trust assets to be included in the estate of the Grantor, thus allowing for the step up in basis.[7]

### F. Summary

When drafting an Asset Protection Trust as part of a Medicaid plan, it is important to understand the tax treatment of the trust depending upon the trust provisions. The elder law attorney has an opportunity not only to protect assets for the senior in terms of long-term care but also to minimize income and estate taxation with a properly drafted Irrevocable Living Trust.

## Endnotes

1. Vincent J. Russo & Marvin Rachlin, New York Elder Law Practice (West 2004) § 13:50, p. 883; § 13:53, p. 884; § 13:54, at 884–885; IRC § 2036(a)(2).
2. References in this outline to the "Code" refer to the Internal Revenue Code.
3. Vincent J. Russo & Marvin Rachlin, New York Elder Law Practice (West 2004) § 13:50, p. 883; § 13:56, at 886–887.
4. Vincent J. Russo & Marvin Rachlin, New York Elder Law Practice (West 2004) § 15:14, at 976–982.
5. Vincent J. Russo & Marvin Rachlin, New York Elder Law Practice (West 2004) § 13:52, p. 884; IRC § 2036(a)(1), IRC § 2036(a)(2); IRC § 1014.
6. The trust assets may not receive step up in basis treatment effective after 2009. *See* EGTRRA 2001, 541, amending IRC § 1014.
7. Vincent J. Russo & Marvin Rachlin, New York Elder Law Practice (West 2004) § 13:53, at 884; IRC § 2036(a)2); IRC § 1014.

**Vincent J. Russo, J.D., LL.M., CELA, Managing Shareholder of the Long Island law firm of Vincent J. Russo & Associates, P.C. of Westbury, Islandia, Woodbury, Lido Beach and Smithtown, New York, has a Masters of Law in Taxation, and is admitted to the New York, Massachusetts and Florida state bars. He is the co-author of *New York Elder Law Practice*, published by West Publications and *When Someone Dies in New York and A Will Is Not Enough In New York*. Mr. Russo is a Founding Member and Past Chair of the Elder Law Section, New York State Bar Association (currently Chair of the Leadership Task Force), a Founding Member, Fellow and Past President of the National Academy of Elder Law Attorneys (NAELA) (currently Chair of the Medicaid Task Force) and Co-Founder of the Theresa Alessandra Russo Foundation which supports children with disabilities.**





# Fair Hearing News

By Ellice Fatoullah and René Reixach

*We actively solicit receipt of your fair hearing decisions. Please share your experiences with the rest of the Elder Law Section and send your fair hearing decisions to either Ellice Fatoullah, Esq., at Fatoullah Associates, Two Park Avenue, New York, New York 10016 or René H. Reixach, Esq., at Woods Oviatt Gilman LLP, 700 Crossroads Building, 2 State Street Rochester, New York 14614. We will publish synopses of as many relevant fair hearing decisions as we receive and as is practicable.*

## *In the Matter of the Appeal of XX*

### Holding

All excess income of a recipient for nursing home Medicaid benefits may be deposited into a Supplemental Needs Trust ("SNT") established for the recipient's disabled child, thereby reducing the recipient's NAMI to $0.

**Ellice Fatoullah**

### Facts

On September 30, 2003, an application for Medical Assistance ("Medicaid") was filed on behalf of the Appellant, age 88.

On April 7, 2004, the application was accepted, retroactive to June 23, 2003, the date Appellant entered his residential health care facility. The authorization required the Appellant to apply $3,118.13 per month of Net Available Monthly Income ("NAMI") for the period October–December 2003, and $3,155.15 per month of Net Available Monthly Income for the period effective January 2004, toward the cost of the Appellant's medical care.

The Appellant received Social Security income at the rate of $2,154.70 per month in 2003 and $2,199.60 per month effective January 2004, of which $58.70 in 2003 ($66.60 effective January, 2004) was offset to cover Medicare premiums. Appellant received $1,350 in monthly pension benefits and $24.77 in monthly Keogh plan distributions. The Appellant also had private health insurance costing $302.64 per month.

On April 21, 2004, the Appellant requested this fair hearing.

### Applicable Law

18 N.Y.C.R.R. §§ 360-4.81 and 360-4.8(b) provide that all income and resources actually or potentially available to a Medicaid applicant or recipient must be evaluated, and such income and/or resources as are available must be considered in determining eligibility for Medicaid. A Medicaid applicant or recipient whose net available non-exempt resources exceed the resource standards will be ineligible for Medicaid coverage until he or she incurs medical expenses equal to or greater than the excess resources.

**René H. Reixach**

18 N.Y.C.R.R. § 360-1.4(c) defines Chronic Care budgeting as a procedure used for individuals who are in "Permanent Absence" status. For such individuals, Chronic Care budgeting begins as of the first day of the calendar month following the month in which the individual is determined to be in permanent absence status.

Under 18 N.Y.C.R.R. § 360-1.4(k), Permanent Absence status means an individual is not expected to return home. Unless overcome by adequate medical evidence, it will be presumed than an individual will not return home if:

(1) a person enters a skilled nursing or intermediate care facility;

(2) a person is initially admitted to acute care and is then transferred to an alternative level of care, pending placement in a residential health care facility; or

(3) a person having no community spouse remains in an acute care hospital for more than six calendar months.

To determine financial eligibility, a person's net income must be calculated. Ordinarily, for cases *not* in Chronic Care, net income is derived by deducting exempt income and allowable deductions from gross income. 18 N.Y.C.R.R. § 360-4.6 sets forth allowable exemptions, deductions and disregards from income. In determining net income for a person in Chronic Care, the amount required for payment of health

insurance premiums is allowed as a deduction, and the amount of $50 is deducted as a monthly Personal Needs Allowance ("PNA") for a resident of a residential health care facility or a person in permanent absence status in an acute care hospital. Residents of psychiatric care facilities, developmental centers or intermediate care facilities under Article 31 of the Mental Hygiene Law are allowed a PNA of $35 per month. A PNA of up to $90 is allocated to a person receiving a pension under 38 U.S.C. § 5503(f) or who has elected a greater compensation benefit under 38 C.F.R. § 3.701 in lieu of such pension. In addition, an amount will be set aside to meet maintenance needs of dependents in the Appellant's former household. 18 N.Y.C.R.R. s 360-4.9.

18 N.Y.C.R.R. § 360-4.(c)(2) provides for transfers made by an applicant/recipient or his or her spouse on or after August 11, 1993 as follows:

> (i) Definitions.
>
> (a) Assets include all income and resources of the individual and of the individual's spouse, including income or resources to which the individual or the individual's spouse is entitled but does not receive because of any action or inaction by the individual or the individual's spouse.
>
> (iii) Exceptions. An individual will not be ineligible for Medicaid as a result of a transfer as described in subparagraph (ii) of this paragraph if:
>
> (a) the asset transferred was a disregarded or exempt asset under sections 18 N.Y.C.R.R. §§ 360-4.4(d), 360-4.6 and 360-4.7, other than a homestead; or
>
> ( c ) (1) the asset was transferred:
>
> (iii) to the individual's child who is blind or disabled, or to a trust established solely for the benefit of such child.

A Medicaid authorization may be issued for necessary medical costs exceeding the net available monthly income (NAMI).

### Discussion

The Appellant's representative did not dispute the Agency's computations. However, the Appellant's representative contended that Appellant should have a $0.00 NAMI because the income received by Appellant was being deposited into a Supplemental Needs Trust established for a disabled child. Effective August 1993, appropriate regulations were broadened to permit the transfer of income as well as resources under certain conditions without penalty. Pursuant to 18 N.Y.C.R.R. § 360-4.4(c)(iii), one such exemption was the transfer of income to an individual's child who is blind or disabled, or to a trust established solely for the benefit of such child. Appellant is transferring his income into the Supplemental Needs Trust established for a disabled child. Appellant submitted documentation into the hearing that the Appellant's income is being deposited monthly into the Supplemental Needs Trust. Accordingly, such income deposited into the trust is exempt for purposes of Medical Assistance. The Agency's reliance on Administrative Directive 89 ADM 45, that only resources can be transferred, was misplaced as the regulation was subsequently amended. Therefore, the Agency's determination that Appellant had a monthly NAMI of $3,118.13 in 2003 and a monthly NAMI of $3,155.15 effective January 2004 cannot be sustained at this time.

### Fair Hearing Decision

The Agency's determination that the amount of the Appellant's contribution toward the cost of the Appellant's care is not correct and is reversed. The Agency is directed to recompute eligibility, exempting all income deposited into the Supplemental Needs Trust established for the benefit of Appellant's disabled child.

### Editors' Comment

This decision is based on the principle that income is resources for transfer of assets purposes—and all the exemptions that apply to the transfer of resources, apply to the transfer of income on a monthly basis. Since resources may be transferred from an Applicant to a disabled child or to a Supplemental Needs Trust for the benefit of a disabled child, as an exempt transfer for Medicaid eligibility purposes, then income directly deposited into the Supplemental Needs Trust may also be so exempted.

The Appellant at this Fair Hearing was represented by **Joan Lensky Robert, Esq.**, of Rockville Centre, New York.

*Copies of the fair hearing decisions analyzed above may be obtained by visiting the Western New York Law Center, at www.wnylc.net/fairhearingbank.*

**Ellice Fatoullah is the principal of Fatoullah Associates, with offices in New York City and New Canaan, CT. She is Chair of the Litigation Committee of the New York State Bar Association's Elder Law Section, a Fellow of the National Academy of Elder Law Attorneys, on the Executive Committee of the Elder Law Section of the Connecticut Bar Association, and a Board Member of FRIA, a New York City advocacy group monitoring quality of care issues in nursing homes. Ms. Fatoullah was the founding Chair of the Elder Law Committee of the New York County Bar Association, founding Chair of the Public Policy Committee to the Alzheimer's Association—NYC Chapter, and a member of its board for seven years. In addition, Ms. Fatoullah was appointed to served on the New York State Task Force on Long-Term Care Financing, an advisory group created by Governor Pataki and the New York State Legislature to study long-term care reform. She has taught Health Law at both Columbia and New York University Schools of Law, and litigation skills at Harvard Law School. She writes and lectures regularly on issues of concern to the elderly and the disabled. In 2002, the New York State Bar Association's Elder Law Section awarded her, along with René Reixach, the first "Outstanding Practitioner Award" . . . "in recognition of her dedication and achievements in the practice of Elder law."**

**René H. Reixach is an attorney in the law firm of Woods Oviatt Gilman LLP, where he is a member of the firm's Health Care Law Practice Group and responsible for handling all health care issues. He is Chair of the Committee on Insurance for the Elderly of the New York State Bar Association's Elder Law Section. Prior to joining Woods Oviatt, Mr. Reixach was the Executive Director of the Finger Lakes Health Systems Agency. Mr. Reixach authors a monthly health column in the *Rochester Business Journal* and has written for other professional, trade and business publications. He has lectured frequently on health care topics. Mr. Reixach has been an Adjunct Assistant Professor in the Department of Health Science at SUNY Brockport. He also appeared as an expert witness on Medicaid eligibility for the New York State Supreme Court. Mr. Reixach also has served on many advisory committees, including the New York State Department of Health Certificate of Need Reform Advisory Committee and the Community Coalition for Long Term Care. Among Mr. Reixach's civic and charitable involvements are serving as a Board Member and President of the Foundation of the Monroe County Bar, President of the Greater Upstate Law Project, and a Board Member of the Yale Alumni Corporation of Rochester.**

# Public Elder Law Attorney News

## Correction and Update to Article on Holocaust Compensation Payments' Effect on Eligibility for Medicaid and SSI

By Valerie Bogart

*Thanks to the Conference on Jewish Material Claims Against Germany, Inc. (Claims Conference), http://www.claimscon.org, for providing information contained in the article. Since 1936, Selfhelp Community Services has pursued its mission of providing a wide range of home and community-based services to survivors of Nazi persecution. Today, Selfhelp cares for a greater number of Holocaust survivors than any organization of its kind in North America.*

Soon after the article on Holocaust compensation payments was submitted for publication in the Summer 2004 issue (page 40), changes were made in federal law that affect the treatment of interest earned on resources, both countable resources and excluded resources such as reparations accounts. These legislative changes alter footnote 11 of that article and the surrounding text. Please substitute the following answer to the following question in the original article. Additionally, please note that the Claims Conference website now has an online calculator worksheet for converting deutschmarks or euros to dollars when determining total reparations received. This worksheet is at http://www.claimscon.org/index.asp?url=payments_benefits.

### Are interest or dividends earned on saved restitution payments also disregarded?

While federal programs vary as to whether or not they count as "income" the interest earned on saved reparations, the Social Security Protection Act of 2004 significantly improved previous SSI policy on this issue.[1] Since Medicaid rules that apply to elderly, blind or disabled individuals may not be stricter than SSI rules,[2] these changes also apply to Medicaid. Section 430 of this 2004 law provides that dividends or interest earned on resources not excluded under section 1613(a) of the Social Security Act or excluded under other federal statutes are excluded as income for SSI benefits payable on or after July 1, 2004. This exemption thus applies to interest or dividends earned on (1) otherwise countable, non-excluded resources, such as a savings account, and (2) resources excluded under other Federal statutes, such as reparations paid to Nazi victims.

Prior to July 1, 2004, interest earned on unspent payments to victims of Nazi persecution was *not* excluded as income for SSI. For SSI benefits payable *on or after* July 1, 2004, interest earned on unspent payments to victims of Nazi persecution is excluded from income.[3] Since Medicaid rules for elderly, blind and disabled persons can be no less strict than SSI rules, interest on reparations accounts may no longer be counted as income by any Medicaid programs in the U.S. *See* note 2.

However, though interest earned on saved reparations does not count as "income" for SSI and Medicaid, if the interest is saved beyond the month it is earned, then it counts as a "resource." There is nothing in the Social Security Protection Act of 2004 that exempts *resources* that are composed of interest earned on reparations, even though the income was exempt as *income* in the month generated. In fact the POMS revisions implementing the 2004 changes specifically state that "interest or dividends may be countable resources if retained into the following month."[4]

*"Since Medicaid rules for elderly, blind and disabled persons can be no less strict than SSI rules, interest on reparations accounts may no longer be counted as income by any Medicaid programs in the U.S."*

A question arises of whether the client must withdraw the interest earned each month from the restitution account, so that the exempt reparations are not commingled with the non-exempt savings attributable to interest. Since this new law that exempts interest as "income" is new, effective only on July 1, 2004, we do not know exactly how the Social Security Administration and Medicaid programs will answer this question. There are two possible arguments for why the non-exempt interest need not be withdrawn, at least in some cases.

First, in cases where the balance of the restitution account is less than the amount of restitution the

client actually received over the years, arguably, the entire account should remain exempt, including the saved interest. There is no first-in-first-out rule for counting total reparations received and saved. The client never has to prove that the reparations account actually contains reparations saved from the 1960s, but only that the total balance of the account is less than the total amount of reparations received. If, for example, the client received $100,000 in restitution over the years, but saved only $60,000, even with interest on the $60,000, the total balance is still *below* the $100,000 of restitution she received. It is not yet known if the government agencies will accept that view, or will require the client to withdraw the interest each time the interest is posted, and spend it or transfer it to the regular savings account. The regular account, as stated above, must be kept below the savings limits for the particular program—whether SSI, Medicaid, or another program.

Second, even if the interest earned on the reparations becomes a countable resource in the following month, the client should not be required to withdraw the interest or keep it separately from the reparations. In instruments such as certificates of deposit, withdrawal of interest in the month generated could trigger withdrawal penalties or other adverse consequences. Thus it is preferable to leave the dividends or interest to accrue in the same account. There is support in the POMS for the right to retain dividends or interest, which becomes a countable resource, in the exempt reparations account. Regarding commingling of exempt and non-exempt resources, the POMS says that "[o]therwise excludable funds must be identifiable in order to be excluded."[5] However, "Identifiability does not require that excluded funds be kept physically apart from other funds" (e.g., in a separate bank account.). *Id*. It should be sufficient to keep track of the interest earned, with a tally of the total amount of the reparations account attributable to interest. That portion of the account is countable as a resource. The client must make sure that the amount of total interest earned, when added to the client's other countable savings accounts, does not exceed the resource limit for the particular federal program (e.g., $3,950 for Medicaid in New York for a single person). The client may need to withdraw and spend some of the interest on the reparations from time to time, to keep her total *countable* savings under the allowable limits for the program.

## Endnotes

1. Sec. 430 of Public Law 108-203 (H.R. 743), signed Mar. 2, 2004, amending 42 U.S.C. § 1382a(b)(21)–(23), effective July 1, 2004.
2. 42 U.S.C. § 1396a(a)(10(C)(i)(II), 42 C.F.R. §§ 435.831(b), 435.845, 436.601.
3. *See* Social Security Administration Program Operations Manual System (POMS) section SI 00830.710 at http://policy.ssa.gov/poms.nsf/lnx/0500830710 and SI00830.500C at http://policy.ssa.gov/poms.nsf/lnx/0500830500#C.
4. POMS § SI 00830.500 sec. E.
5. POMS SI 01130.700.

**Valerie Bogart is senior attorney for the Evelyn Frank Legal Resources Program at Selfhelp Community Services in New York City. She received her J.D. from New York University School of Law.**

# Advance Directive News

## The Undoing of a Peaceful Passing

By Ellen G. Makofsky

They found him in his most comfortable chair, head back, arms crossed. At 90 years he had just recently begun calling an assisted living facility home. The day's activity was joyous and included a trip to see a local production of a well-remembered musical. He returned to his apartment to enjoy a catnap before dinner. He never awoke. Mr. Z died sometime before anyone looked in on him.

When Mr. Z was discovered in his room, 911 was called, and this began an unfortunate chain of events. Under New York State law, where there is no contrary direction in regard to an individual's wishes there is a presumption for resuscitation.[1] This presumption can result in very aggressive actions taken in an attempt to bring a very fragile person back to life. The presumption to resuscitate can be overcome with a Do-Not-Resuscitate Order ("DNR")[2] placed in a patient's chart by a physician.[3]

When Mr. Z took up residence in the assisted living facility he signed a non-hospital DNR[4] and the assisted living facility took control of the original document. Mr. Z felt he made an appropriate choice in agreeing to the DNR because Mr. Z knew a resuscitation attempt caused a great deal of physical trauma and the likelihood of a successful resuscitation was not high. Mr. Z's concern was well-founded. Statistics show when evaluating actual success rates for post-cardiopulmonary resuscitation ("CPR") survival, a mere 5 percent of hospitalized patients who receive CPR recover and resume their regular lives. For nursing home and assisted living residents the success for unobserved arrests is between zero and 3 percent.[5]

So what happened to Mr. Z? Once 911 was called and the emergency medical technicians ("EMTs") arrived they properly asked if a DNR order existed. Without affirmative knowledge of the DNR the EMTs could not withhold CPR. It was evening and the facility's more knowledgeable daytime staff was unavailable. While staff members scurried around the assisted living facility trying to locate the DNR, the EMTs were obliged to begin and continue the unwanted CPR on Mr. Z. The DNR that everyone knew existed was not found that night and the CPR was discontinued twenty–five minutes after it was begun when Mr. Z's son was contacted by phone. Mr. Z's son, by telephone, gave a verbal instruction to discontinue CPR.

Mr. Z had a good plan that went wrong. What can we as elder law attorneys learn from this scenario? First, we need to really advise our clients what a presumption for resuscitation means and the importance of having a DNR in place in the appropriate situation. Second, we need to counsel our clients that they must be vigilant to assure that the DNR is readily available to those who must rely upon the document.

### Endnotes

1. Section 2962 Pub. Health.
2. A DNR order is limited to withholding cardiopulmonary resuscitation in the event a person suffers a cardiac or respiratory arrest.
3. Article 29-B Pub. Health.
4. There is a requirement that a non-hospital DNR must be reviewed by the attending physician every time the physician examines the patient or at least every 90 days to be sure that the DNR order is still appropriate. Section 2977(8) Pub. Health.
5. Christopher, M., *End-of-Life Care Reform: Is It About "Us " or "Them"?*, NAELA Quarterly, Vol. 14, No. 2, Spring 2001, citing Jim Stoddard, *A Practical Approach to DNR Discussions*, 14 Bioethics Forum XXX (1998).

**Ellen G. Makofsky is a *cum laude* graduate of Brooklyn Law School. She is a partner in the law firm of Raskin & Makofsky with offices in Garden City, New York. The firm's practice concentrates in elder law, estate planning and estate administration. Ms. Makofsky is a member of the New York State Bar Association ("NYSBA") and serves as the Secretary of its Elder Law Section's Executive Committee. She is also a member of the NYSBA's Trusts and Estates Law Section. Ms. Makofsky is a member of Nassau County Bar Association, Elder Law, Social Services and Health Advisory Committee and the Surrogate's Court Trusts and Estates Committee. She is a member of the National Academy of Elder Law Attorneys, Inc. ("NAELA"). Ms. Makofsky is also a member of the Executive Board of the Estate Planning Council of Nassau County, Inc.**

**Ms. Makofsky is Co-chair of the Senior Umbrella Network of Queens and is the immediate past co-chair of the Long Island Alzheimer's Foundation ("LIAF") Legal Advisory Board. She has served as president of the Gerontology Professionals of Long Island, Nassau Chapter, and as chair of the Senior Umbrella Network of Nassau. She serves on the Board of Directors of Landmark on Main Street.**

# Guardianship News

By Robert Kruger

Article 81 is a relatively new statute, having become effective on April 1, 1993. We have not yet developed a body of law on many Article 81 issues.

What I have chosen to do in this article, and will probably do, if given the opportunity in some future articles, is discuss an area that troubles me, and these areas, almost always, contain little, if no, decisional guidance. Therefore, this article is, basically, my musings, not an analysis of authority.

Three years ago, I wrote an article in this column about the different standards for the withdrawal of infants' funds under Article 12 of the CPLR, Article 17 of the SCPA and Article 81 of the MHL.

For those with long memories, the standard for withdrawals under Article 81 is the most liberal, particularly since section 81.21(a)(1) provides that the funds of an Incapacitated Person (not limited to infants) can be used for the support of a person for whom the IP has no obligation of support.

My experience, broadened by the anecdotal experience of other practitioners who I shamelessly pump on this subject, is that there is no reliable standard to guide us on the propriety of an application to use an infant's funds in the guardianship context.

These applications usually involve the holy trinity for the child's family: van, house and stipend. Of these, the van, in my experience, is the easiest to obtain approval for. Most of the children have disabilities. After all, the child did not receive a settlement for nothing. Transporting a child who is hyperactive or who suffers from disabilities—to doctors' appointments, to hospitals when an emergency arises, to physical therapy—may involve a situation that is life-threatening. For a poor family, the van is a necessity and it is *obviously* a necessity. Therefore, the court is usually sympathetic.

The court, however, may be less sympathetic if the family wants to load up the van with options. My solution, if the family's agenda is a bit too grandiose, is to suggest that the family pay for the extras, not the child.

Turning to the house purchase, if the family is poor, the neighborhood they live in is usually substandard, and often unsafe and crime-ridden. Most judges, therefore, are sympathetic to an application to purchase a new home for the family.

One issue that must be addressed is the affordability of the purchase. Does the guardianship have sufficient funds to meet other needs of the IP? Doing a financial analysis, in my view, is mandatory. If the court is uneasy about the cost vis-à-vis the resources remaining, the application may be rejected.

Further, what are the other needs of the IP? Is the child medically stable? Are you spending a fortune on medications? Is an SNT necessary? Can private medical insurance pay sufficiently to protect the child?

A second issue to address is the tremendous increase in cost of housing, particularly in the downstate area south of the Tappan Zee Bridge. It is important to present the court with sufficient comparables, or an appraisal, to demonstrate the fairness of the price. Somewhat harder to address is the court's sticker shock: the judge may have purchased his/her house a generation ago, at prices now unrecognizably low. The notion that it is appropriate to use an infant's funds to purchase a million-dollar house may be too much for the court to overcome.

Even with a clear demonstration of affordability, in April 2004, a downstate judge refused to sign an order to show cause to purchase a ***$900,000*** house . . . in an upscale neighborhood. The family could, and subsequently did, find a ***$700,000*** house which was probably a better house than the more expensive house. This the court did approve. However, courts are justifiably concerned that the child not support the family, and a very expensive house in a very prestigious neighborhood may trigger a negative response from a judge—particularly when the family does not contribute to the purchase or to carry the house.

Once the house is purchased, furnishing the house comes next. With a middle-class family, the cost of furnishing the house, with the exception of the furniture in the bedroom of the Incapacitated, should largely be borne by the parents. Perhaps, the child, in a family of four, can fairly be charged with 25% of the cost of furnishing the common rooms in the house. It would not be appropriate however, to have the child in a middle-class family pay the cost of furnishing the parents' bedroom.

For a poor family, the calculus changes. It makes no sense to permit a family to purchase a house but refuse to permit them to furnish that house. Therefore, so long as the family is reasonable, and the funds allow it and the family avoids grandiosity (an expensive chandelier, for example), I pay for the furniture and await the annual accounting for the day of reckoning.

This may be controversial because significant monies are being expended without court approval. I might be more amenable to seeking court approval if court approval could be obtained in a timely fashion. However, as I think about it, I cannot recall even one instance when I sought judicial approval to purchase furniture *after* having received permission to purchase a house.

I invariably seek judicial approval to rehabilitate, expand, reconfigure or adapt for handicapped accessibility. Any construction on that house requires judicial approval but, because a family cannot live in a house without furniture, the court's approval is assumed (at least by me) in the annual accounting (again), so long as the family is reasonable.

The hardest issue in the realm of withdrawals involves a stipend for the family, usually the mother. Certainly, when there is a Supplemental Needs Trust, the Medicaid agencies often oppose the stipend for a parent while blandly accepting a companion or aide whose cost is scarcely less. The Medicaid agencies are headed by people whose life experience rarely, if ever, involves caring for a disabled child (or other relative); if it did, they would confront the reality of caring for a disabled child. Incidentally, the Medicaid staff will often be far more sympathetic (and realistic) on this issue.

With a disabled child, even a child in school, the parent (usually a single parent—the mother) cannot work. If the child is medically stable, there are few openings for someone working a 9:30 a.m. to 2:45 p.m. shift. If these jobs exist, they pay little. If the child is medically fragile, or has a behavior problem, the parent is essentially on call. Who can find productive employment in these conditions? Why not pay the mother the money the home care companion would cost?

Beyond the Medicaid agency's resistance, however, is the attitude of a court often resistant to the notion of the child supporting the family. We all have clients who want to live off the child's money—the perception being that the child's money is their money collectively, not the child's money alone. These parents, if their child's guardianship proceeding is before an unsympathetic judge, are in for years of diminished expectations, as is the attorney unlucky enough to represent such parents.

While questioning the attitude of the courts, it is nevertheless hard to be sanctimonious—there are far too many families who are "entitled." This sense of entitlement is sufficient to stifle the enthusiasm of the most zealous advocate.

At the recent Elder Law Section summer meeting at Mohegan Sun, Thomas Begley spoke about managing the expectations of the family. This is much easier to accomplish if we, as attorneys, know the attitude of the court from our experience before it. It is much harder to do when the court lacks experience in guardianship and SNTs. Yet, if the funds are ample, and the child's welfare is secure, what is the harm indeed if the stipend is generous? If the family resided in the projects, counsel is dealing with a culture of poverty. The child's recovery will benefit from the eased circumstances of the family. In my opinion, there is much to be said, particularly when there is no Supplemental Needs Trust, for a somewhat liberal attitude toward a comfortable stipend. Or a family insurance policy, rather than an individual one.[1] Not all judges agree and if you are appearing before such a judge, or even if you are not, you would be well-advised to create a budget for the family, certainly demonstrate that there are ample resources (and income) on hand to afford the stipend (and avoid depletion of principal), and describe what services the mother provides the child—which leads to the corollary—why the mother cannot work. If the custodial parent is a father who does not work, be very careful.

* * *

I invite letters and comments from the bar and the judiciary. I can be reached at 225 Broadway, Suite 4200, New York, NY 10007; phone number: (212) 732-5556; fax: (212) 608-3785; and e-mail address: RobertKruger@aol.com.

## Endnote

1. It is preferable, in my view, to have a family policy for several reasons. If there are other children, I would not wish to perpetuate a class system where one child, the IP, receives private medical care and the other children go to a clinic. If the funds are adequate, insuring the parents protects the child, particularly (and obviously) when the parents are caregivers.

**Robert Kruger is the Chair of the Committee on Guardianships and Fiduciaries, Elder Law Section of the New York State Bar Association. He is also Chair of the Subcommittee on Financial Abuse of the Elderly, Trusts and Estates Section, New York State Bar Association. Mr. Kruger is an author of the chapter on guardianship judgments in *Guardianship Practice in New York State* (NYSBA 1997) and Vice President (four years) and a member of the Board of Directors (ten years) for the New York City Alzheimer's Association. He was the Coordinator of the Article 81 (Guardianship) training course from 1993 through 1997 at the Kings County Bar Association and has experience as a guardian, court evaluator and court-appointed attorney in guardianship proceedings. Robert Kruger is a member of the New York State Bar (1964) and the New Jersey Bar (1966). He graduated from the University of Pennsylvania Law School in 1963 and the University of Pennsylvania (Wharton School of Finance (B.S. 1960)).**

# National Case News

## *Oregon v. Ashcroft* and Physician-Assisted Suicide

By Steven M. Ratner

In *Oregon v. Ashcroft*,[1] a doctor, a pharmacist, several terminally ill patients, and the State of Oregon challenged a directive issued by Attorney General John Ashcroft which declared that physician-assisted suicide violates the Controlled Substances Act of 1970. Holding that the Ashcroft Directive was unlawful and unenforceable, the Ninth Circuit found that the directive violated that plain language of the Act, contravened Congress' express legislative intent, and overstepped the bounds of the Attorney General's authority.

The Controlled Substances Act (the Act, or CSA) was enacted by Congress as part of the Comprehensive Drug Abuse Prevention and Control Act of 1970. The stated purpose of the Act is to "provide increased research into, and prevention of, drug abuse and drug dependence . . . and to strengthen existing law enforcement authority in the field of drug abuse." Under the Act, it is unlawful to prescribe or dispense controlled substances without a federal registration. In 1971, then-Attorney General John Mitchell promulgated the following regulation:

> A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. An order purporting to be a prescription issued not in the usual course of professional treatment is not a prescription within the meaning and intent of the Act and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of the law relating to controlled substances.[2]

Originally, the Act only allowed the Attorney General to revoke a practitioner's federal registration if the practitioner falsified his or her registration application, was convicted of a felony related to a controlled substance, or had his or her state license suspended or revoked. However, in 1984, Congress amended the Act to give broader authority to the Attorney General, authorizing him to revoke a physician's prescription privileges upon the determination that the physician had "committed such acts as would render his registration . . . *inconsistent with the public interest*."[3] When determining which acts are inconsistent with the public interest, the Attorney General must consider the following five factors:

1. The recommendation of the appropriate State licensing board or professional disciplinary authority;
2. The applicant's expertise in dispensing controlled substances;
3. The applicant's conviction record under the Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances;
4. Compliance with applicable State, Federal, or local laws relating to controlled substances;
5. Such other conduct which may threaten the public health and safety.[4]

*"Oregon's Death with Dignity Act allows physicians to prescribe lethal doses of controlled substances to terminally ill Oregon residents providing the patients' decisions are reasoned and voluntary."*

One decade after this amendment was passed, the state of Oregon, by ballot initiative, enacted the country's first law authorizing physician-assisted suicide. Oregon's Death with Dignity Act allows physicians to prescribe lethal doses of controlled substances to terminally ill Oregon residents providing the patients' decisions are reasoned and voluntary.[5] Under the Act, a resident is only eligible if he or she is suffering from an incurable disease that is likely to result in death within six months. The patient's diagnosis must be confirmed by two independent doctors. Additionally, the patient must sign a written

request for the prescription in the presence of two witnesses indicating that the patient is competent and acting voluntarily.

After Oregon voters reaffirmed their support for the Death with Dignity Act in 1997, several members of Congress, including then-Senator John Ashcroft, urged then-Attorney General Janet Reno to declare that physician-assisted suicide violated the Act. Janet Reno declined the request explaining that the Act was not "intended to displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice." Additionally, she believed that the Act does not permit the Drug Enforcement Administration (DEA) to take action on a physician who has assisted in a suicide in compliance with Oregon law.

*"The [Ashcroft] Directive specifically targets health care practitioners in Oregon and instructs the DEA to enforce this Directive even though it is in direct conflict with state law."*

With the change of administration came a change in policy. On November 9, 2001, newly appointed Attorney General John Ashcroft reversed Janet Reno's position and issued the Directive at issue. The Ashcroft Directive declared that the specific conduct authorized by Oregon's Death with Dignity Act was in conflict with the public interest of Oregon citizens. The Directive specifically targets health care practitioners in Oregon and instructs the DEA to enforce this Directive even though it is in direct conflict with state law.

The Ninth Circuit began its discussion by noting that "all parties agree that the question before us is whether Congress authorized the Attorney General to determine that physician assisted suicide violates the CSA." The court quoted from the Supreme Court decision in *Washington v. Glucksberg*[6] for the proposition that "earnest and profound debate about the morality, legality, and practicality of physician assisted suicide" belongs among state lawmakers.

The Ninth Circuit believed that by criminalizing medical practices specifically authorized by Oregon law, the Ashcroft Directive interfered with Oregon's authority to regulate medical care and therefore "altered the usual constitutional balance between States and the Federal Government." Under these circumstances, the court stated that it was incumbent on the federal courts to be certain of Congress' intent before finding that federal authority supersedes state law.

The court concluded:

> The Ashcroft Directive is invalid because Congress has provided no indication—much less an unmistakably clear indication—that it intended to authorize the Attorney General to regulate the practice of physician assisted suicide. By attempting to regulate physician assisted suicide, the Ashcroft Directive invokes the outer limits of Congress' power by encroaching on state authority to regulate medical practice. Because Congress has not clearly authorized such an intrusion, the Ashcroft Directive violates the clear statement rule.[7]

According to the Ninth Circuit, the Ashcroft Directive not only lacked clear Congressional authority, it also violated the plan language of the Act. The court stated that the statute "expressly limits federal authority under the Act to the field of drug abuse." Contrary to the Attorney General's characterization, the court did not believe that physician–assisted suicide was a form of drug abuse that Congress intended the Act to cover. "Physician assisted suicide is an unrelated, general medical practice to be regulated by state lawmakers in the first instance."

The court stated that it knew that Congress intended to limit federal authority under the Act to the field of drug abuse because the statute's non-preemption clause provides that the Act shall not be construed to preempt state law unless there is a positive conflict between the text of the statute and state law. The court concluded that no provision of the Act directly conflicts with Oregon's Death with Dignity Act. However, the Attorney General's expansive interpretation of the Act clearly conflicts with Oregon law and therefore could not be squared with the Act's non-preemption clause.

The court recognized that the Attorney General is authorized to revoke prescription privileges from physicians for "conduct deemed *inconsistent with public interest*." Ashcroft argued that physician–assisted suicide was inconsistent with the public interest because the practice threatened public health. The court noted that while threat to public health is one factor to consider when determining the public interest, the Attorney General failed to consider the other four factors set forth in 21 U.S.C. § 823(f). The Ninth Circuit wrote: "The Attorney General misreads the Act when he concludes that he may evaluate the public interest based on any of the five factors identified

in the statute. The CSA clearly provides that all five public interest factors shall be considered."

The Ninth Circuit next turned to the legislative history of the Act. The court believed that the legislative history showed that: "Congress clearly intended to limit the CSA to problems associated with drug abuse and addiction."

Given the plain language of the Act and its legislative record, the court stated that it was under no obligation to defer to the Attorney General's interpretation of his role under the Act and its regulations. The court wrote: "Agency determinations that squarely conflict with governing statutes are not entitled to deference."

The court also noted that the "Attorney General has no specialized expertise in the field of medicine and that he imposes a sweeping and unpersuasive interpretation of the CSA—which directly conflicts with that of his predecessor—without notice or comment. There is no reason to defer to his interpretation under the CSA."

In sum, the Ninth Circuit believed that the CSA was enacted to combat drug abuse and that the Attorney General's unilateral attempt to regulate general medical practices historically entrusted to state lawmakers interfered with the democratic debate about physician-assisted suicide and far exceeded the scope of his authority.

## Endnotes

1. 368 F.3d 1118 (May 26, 2004).
2. 21 C.F.R. § 1306.04.
3. 21 U.S.C. § 824(a)(4).
4. 21 U.S.C. § 823(f).
5. Or. Rev. Stat. § 127.900-897.
6. 521 U.S. 702 (1997).
7. 368 F.3d at 1125.

**Steven M. Ratner is the founder of the Law Office of Steven M. Ratner, P.C., a firm committed to serving the needs of the elderly, with offices in Manhattan, White Plains, and Carmel. Mr. Ratner is a frequent lecturer and author on issues within his practice areas and is the co-author of the Elder Law chapter in the *New York Lawyer's Deskbook*.**

**Steven M. Ratner graduated from the University of Oregon School of Law where he was first in his class, a member of the Order of the Coif, and an Associate Editor of the *Oregon Law Review*. Mr. Ratner received an LL.M. in Taxation from New York University where he was a Student Editor of the *Tax Law Review* and the recipient of the Harry J. Rudnick Memorial Award.**

**Mr. Ratner's work experience includes a one-year clerkship with the Honorable Herbert Y.C. Choy of the United States Court of Appeals for the Ninth Circuit in Honolulu, Hawaii.**

# Snowbird News

## The Elder Law Attorney and Mrs. Baker

By Scott M. Solkoff

Rose Baker had been married to her husband, Joe, for 59 years when she first came to me. They had lived their lives together in Penfield, New York, and had retired to South Florida in 1992. When I came out of my office to greet Mrs. Baker in the reading room (we don't have a "waiting" room), her eyes were puffy, red and she was clutching a wrinkled tissue in one hand. I brought Mrs. Baker right back to my office where she immediately related her story to me. Bottom line: Joe is ill and in the nursing home and she, Rose, is depressed, feeling guilty, scared and lonely. On top of it all, she tells me, she is worried about being poor.

She expresses guilt and remorse for even talking about money because, she tells me, she should be at the nursing home taking care of what is really important—her husband, Joe. She is crying again but trying not to. She is embarrassed. I am leaning in from my desk, trying to convey assurance so I can make her feel better. Making her feel better is all I really want to do.

Rose is so obviously overwhelmed with all that is going on in her life. She is talking at once about the doctor at the nursing home, Joe's most recent hospitalization, her daughter who is disabled by reason of multiple sclerosis, her son who cannot do enough but lives "back home" in Penfield, the electric bill being higher this month because it is so hot, her three CDs which total $90,000, the stock which used to be worth $140,000 but is now worth only $100,000. She is talking fast and each burst of words is another weight on her shoulders. She is talking about how Joe used to be an important teacher and how good he was to her and the kids. She is crying off and on. Mrs. Baker reminds me of my grandmother. I feel bad for her but I am used to this.

I take control of the meeting by asking her some questions and filling out my intake form. I do this myself instead of having a staff member do it because I use these innocuous questions to make small talk with my clients. It helps them because they are often nervous and scared, just like Mrs. Baker. I talk with Mrs. Baker and calm her down a little bit. I write down some notes of my impressions and the answers to the questions on my form. I try to write down her own words whenever possible.

Mrs. Baker has two children: a daughter named Hillary and a son name Stephen. Hillary is a "good girl," suffers from multiple sclerosis, and does not "deal well with sad things." Hillary calls once each week but Mrs. Baker does not want to "burden her." Mrs. Baker last saw Hillary eight months ago. It is hard for Hillary to travel because of her MS. Stephen is a teacher, having followed in Dad's footsteps. Stephen is a big help to Mrs. Baker. He was just down for ten days and will be returning next month. Because there is no school in summer, Stephen has some flexibility for the time being.

Mrs. Baker is scared about the money. On top of their regular expenses, Mrs. Baker tells how she just paid the nursing home $5,700 for last month alone. "We never spent money like this," she says. She tells how she and her husband saved and saved their money; how they never had two cars, how Joe "taught me how to put money away for later." She tells me how Joe does not even recognize her sometimes and she starts crying a lot now.

Even though I know I can help Mrs. Baker, I feel frustrated that I cannot do more. I want her to stop crying. I want her to be happy. I want her to feel secure again. I strong-arm my emotions aside and stay with my lawyerly, authoritative and assuring pose. I want her to know that I can help her so she will feel some relief.

I say, "Mrs. Baker, when you leave here today, I want you to leave with a weight taken off of your shoulders. I cannot fix all of the problems, but I can make the money problems less of an issue." These words are manna to her. For the first time, she is with someone who might be able to help. She exhales some years of worry and her shoulders visibly relax.

"How?" She is wobbling her head and looks incredulous. Then she adds, "The money is not important, though." Even in her excitement to maybe have found some help, she feels guilty that we are talking about "money" when her husband is suffering so much.

"Mrs. Baker," I continue, "Money buys care. I cannot make your husband all better. No one can. But what we can do is maximize the use of your savings so that he—and you—can get better care. We do this

through a process of protecting your savings while accessing any and all benefits that will help you and your husband."

I am very cool, very assuring. Inside, I want to jump up and hold Mrs. Baker and cry with her and tell her everything will be alright. But I know that I must convey detached professionalism so Mrs. Baker feels safe.

Like many elder law attorneys, I am a healer at heart. My undergraduate degree is in religion and I had once planned to go into the clergy until I realized I had too many doubts. I satisfy this need now by being an elder law attorney and by doing magic shows. Magic makes people feel good and is less stressful than elder law but I have learned that being a magician and being an elder law attorney take very similar skills. My clients and friends kid me by saying that in one act, I make handkerchiefs disappear and in another act, I make assets disappear. I think this is funny, too, but it also makes me feel uncomfortable.

Some people do not understand what I do as an elder law attorney. Some people think that Medicaid planning means taking rich people and putting them on the public dole. You and I know that this is not true but it is a convenient foil for our detractors.

Mrs. Baker is a composite of my average client and probably that of yours as well—middle-class to upper middle-class people who saved and saved and saved for retirement only to be beaned by a long-term care system that has spiraled out of control. What the government wants is for Mrs. Baker to "spend down" the family savings and then, when there is little or nothing left, Medicaid will help pay for the nursing home. The problem, of course, is that Mrs. Baker then has little or nothing left to pay for those things that Medicaid will not cover. All of their efforts in saving for a lifetime mean nothing. They get no benefit from having saved. Indeed, in the room right next to Mr. Baker, a lady who never saved a penny is receiving the same care on Medicaid. The system is broken.

Our health care system in America chooses which diseases will be covered by the government and which will not be covered. Senior citizens diagnosed with cancer, for example, will receive all necessary health care through our Medicare program. If you have cancer, heart disease or other such illnesses, you are covered. If you are unlucky enough to get Alzheimer's disease or any other form of dementia, you are out of luck. This is because our American health care system, unlike that of other advanced nations, does not cover these diseases which predominantly affect the elderly. This selective health care system is not just.

What is more is that the care Mr. Baker receives is, in my opinion, substandard, even at the "good" facilities. As you know, to remain profitable, nursing homes pay low wages and therefore attract only those people who are willing to do hard and intensely personal work for very little money. The turnover rate for staffing at many nursing homes is very high. Even the better-paid administrators are well known to shift from company to company. The government is not helping enough. The Medicaid reimbursement rate is too low. Nursing homes are regularly filing for bankruptcy protection. Cost-cutting measures mean a greater likelihood of abuse and injuries of nearly helpless nursing home residents. The structure of government programs still forces people into nursing homes rather than paying for assisted living or home care; it's a costly mistake for our government and for our society.

*"Our health care system in America chooses which diseases will be covered by the government and which will not be covered."*

In New York, the government has severely restricted access to the Medicaid program. Planning options that you used to be able to use for your clients have come under attack. The government is not acting as "public servant," but has been aspiring to greatness as a "gatekeeper."

For all of these reasons and more, we know that maximizing the client's own resources is critical.

Through proper planning, I know I can show Mrs. Baker how to protect all or most of the family savings. I can show Mrs. Baker how she can qualify Mr. Baker for Medicaid while still getting the benefit of their savings. By using their own dollars and the government's dollars, Mr. Baker (and Mrs. Baker) will be able to afford more and better care. This can make all the difference.

The New York Court of Appeals put it well when it held that "[n]o agency of the government has any right to complain about the fact that middle class people confronted with desperate circumstances choose voluntarily to inflict poverty upon themselves when it is the government itself which has established the rule that poverty is a prerequisite to the receipt of government assistance in the defraying of the costs of ruinously expensive, but absolutely essential, medical treatment.'"

Mrs. Baker is every client who has walked into our offices full of grief, guilt and fear.

America is a very great nation, but we should not kid ourselves by pretending that we are on the moral high ground when it comes to taking care of our country's parents and grandparents. Without Medicaid planning, Mrs. Baker and her husband have been largely set adrift on ice floes.

*"America is a very great nation, but we should not kid ourselves by pretending that we are on the moral high ground when it comes to taking care of our country's parents and grandparents."*

I do not think I am exaggerating the poor state of long-term care. I will not be too graphic and I would think that each of you can relate consistently tragic details of poor care, but if you think the ice floe analogy goes too far, consider this: Is it morally proper, considering our means, to have people crying out to be taken to a toilet? Is it right to regularly deliver the dinner tray to Mr. Baker's bed and leave it there, knowing that he cannot eat without assistance—the tray then being thrown away without being touched and no thought being given to Mr. Baker's starvation? Is it right to diaper a continent adult so the staff does not need to take him or her to the bathroom? These are just a few things seen every day with millions of nursing home residents in America. We grow numb to it. It is accepted as "the way things are."

What are we becoming? Is not a society judged by how we take care of our children, our sick and our elderly?

Medicaid planning might not solve these "big" issues, but for the individual person who comes to us, it can mean the difference between that person's (or their loved one's) life and death and it almost always means a higher quality of life for one's last weeks, months or years. There are some who may argue the public policy of burdening the tax base for long-term care. For us, as elder law attorneys, with each individual person or family who comes into our office, we can care only about them and making things better. We know that more money means more care. We know that we can show our clients how to protect their savings and access Medicaid to get better care. We know that what we are doing is not only legal but is morally just.

Mr. and Mrs. Baker worked hard for their money. They helped to build this country. As elder law attorneys, in New York or in Florida, we should feel good about doing all we can to make Mr. and Mrs. Baker's lives better. That is what gives me pleasure and I hope you can and do feel the same.



**Scott M. Solkoff is Chair-Elect of the Florida Bar's Elder Law Section and a principal with Solkoff & Zellen, P.A., a law firm exclusively representing the interests of the elderly and disabled throughout Florida.**

# Quotes to Remember

## Health Care Proxy Held Sufficient to Obtain Medical Records

By Natalie J. Kaplan

Many of us know that the Health Insurance Portability and Accountability Act (HIPAA) preempts state law, except where state law is "more stringent." How many of us know, however, the HIPAA definition of "more stringent"? Be forewarned, it's counterintuitive. A state law is more stringent and, hence, governs:

> if it creates greater rights of access or amendment; . . . [or] provides more control to the patient over the form or substance of patient authorization and consent. . . .[1]

Relying on this definition, a Nassau County Supreme Court concluded that a New York health care proxy provides sufficient authority to grant a health care agent access to HIPAA-protected records. In *Mougiannis v. North Shore–Long Island Jewish Health System*,[2] the court held for the application of New York proxy law stating:

> [New York] Public Health Law §2982(3)[3] makes the right of a health care agent to medical information clear . . . [A] validly executed Health Care Proxy qualifies the [agent] to . . . stand in stead of the "subject" for the purpose of requesting access to past medical records which may have great bearing on present day treatment determinations.

If this decision is adopted elsewhere, it will go a long way to allaying the concerns of many about the use of the proxy for obtaining records.

### Endnotes

1. *Mougiannis v. North Shore-Long Island Jewish Health System,* N.Y.L.J., May 19, 2004, p. 19, col. 3 (Sup. Ct., Nassau Co.), quoting Levine, R.J. & Maltz, A., *HIPAA Regulations Unintended Effect; Civil Actions for Inappropriate Disclosure of Patient's Medical Information May Increase*, N.Y.L.J., July 2, 2001, p. 7. *See* 45 C.F.R. § 160.202(2)(4).
2. *Mougiannis v. North Shore–Long Island Jewish Health System. Id.*
3. New York Public Health Law § 2982(3) provides: "Notwithstanding any law to the contrary, the agent shall have the right to receive medical information and medical and clinical records necessary to make informed decisions regarding the principal's health."

**Natalie J. Kaplan is a longtime New York City and Westchester County elder law attorney whose practice includes in-house counseling by Elder Law on Wheels.®**

**Message from the Chair**
*(continued from page 2)*

either of the first two issues of the e-News and/or you wish to receive future issues, please provide your e-mail address to Lisa Bataille at the New York State Bar Association.

7. Our Leadership Task Force (Vincent J. Russo, Chair) has been working to develop a specific plan regarding how the Section attracts new leadership. In that regard, the Task Force has been holding meetings at our Section's programs. Please join us at a future meeting of the Task Force to find out how you can become more involved in Section activities.

8. Elder Law Listserv—let me take this opportunity to remind everyone that our Section maintains one of the Bar Association's most active listservs. Here, you can discuss practice management and legal issues with your colleagues as well as access listserv members as a sounding board for complex situations. If you would like to join the Section's listserv, simply contact Lisa Bataille at lbataille@nysba.org.

There are so many other things going on within the Section. I urge you to get involved in any way that you can. Not only will the Section benefit from your involvement, but you, your professional career and your practice will reap immeasurable returns as well. Please contact me at hkrooks@lkllp.com to learn how you can become more involved.

I wish you all the best.

**Howard S. Krooks**

# Section Committees and Chair

**Client and Consumer Issues**
Margaret Z. Reed
The Law Office of
Margaret Z. Reed
203 Delaware Avenue
Delmar, NY 12054
(518) 439-6001

**Coalition of Bar Advocates**
Walter T. Burke
Burke, Casserly & Gable, P.C.
255 Washington Avenue Ext.
Albany, NY 12205
(518) 452-1961

**Communications**
Steven T. Rondos
Raia & Rondos
466 Bay Ridge Parkway
Brooklyn, NY 11209
(718) 833-6338

**Elder Law Practice**
Sharon Kovacs Gruer
Sharon Kovacs Gruer, P.C.
1010 Northern Boulevard, Suite 302
Great Neck, NY 11021
(516) 487-5400

**Estate and Tax Planning**
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Certilman Balin Adler & Hyman, LLP
90 Merrick Avenue, 8th Floor
East Meadow, NY 11554
(516) 296-7044

**Family Law Issues**
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Hyman & Gilbert
1843 Palmer Avenue
Larchmont, NY 10538
(914) 833-5297

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255 Washington Avenue Ext.
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(518) 452-1961

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140 Grand Street, Suite 701
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Lake Success, NY 11042
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Westbury, NY 11590
(516) 794-9696, ext. 21

**Legal Education**
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Littman Krooks LLP
655 Third Avenue
New York, NY 10017
(212) 490-2020

**Leadership Task Force**
Vincent J. Russo
Vincent J. Russo & Associates, P.C.
1600 Stewart Avenue, Suite 300
Westbury, NY 11590
(516) 683-1717

**Liaison to the Judiciary**
Hon. Edwin Kassoff
Kassoff Robert Lerner and Robert, LLP
100 Merrick Road, Suite 508W
Rockville Centre, NY 11570
(516) 766-7700

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Rose Mary K. Bailly
Law Review Commission
80 New Scotland Avenue
Albany, NY 12208
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Valerie J. Bogart
Selfhelp Community Services Inc.
520 Eighth Avenue, 5th Floor
New York, NY 10018
(212) 971-7693

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Ronald A. Fatoullah
Ronald Fatoullah & Associates
425 Northern Boulevard, Suite 20
Great Neck, NY 11021
(516) 466-4422

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Ellice Fatoullah
Fatoullah Associates
Two Park Avenue
New York, NY 10016
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(315) 233-8263

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Raskin & Makofsky
600 Old Country Road, Suite 444
Garden City, NY 11530
(516) 228-6522

**Long Term Care Reform**
Louis W. Pierro
Pierro & Associates, LLC
21 Everett Road Ext.
Albany, NY 12205
(518) 459-2100

**Medicaid**
René H. Reixach
Woods Oviatt Gilman LLP
700 Crossroads Bldg.
Rochester, NY 14614
(585) 987-2858

**Medicaid In-Kind Issues**
Valerie J. Bogart
Selfhelp Community Services Inc.
520 Eighth Avenue, 5th Floor
New York, NY 10018
(212) 971-7693

**Medicaid Legislation**
Daniel G. Fish
Freedman & Fish, LLP
521 Fifth Ave., 25th Floor
New York, NY 10175
(212) 953-1172

Howard S. Krooks
Littman Krooks LLP
81 Main Street
White Plains, NY 10601
(914) 684-2100

**Membership Services**
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Lamson & Petroff
270 Madison Avenue, Suite 1101
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(212) 447-8690

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MHLS
998 Crooked Hill Road, Bldg. 20
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**Persons Under Disability**
Joan L. Robert
Kassoff Robert Lerner and Robert, LLP
100 Merrick Road, Suite 508W
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**Publications**
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Davidow, Davidow, Siegel & Stern LLP
One Suffolk Square, Suite 330
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**Technology**
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Goldfarb Abrandt Salzman & Kutzin LLP
350 Fifth Avenue, Suite 1100
New York, NY 10118
(212) 387-8400

# ELDER LAW ATTORNEY




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Elder Law Section
New York State Bar Association
One Elk Street
Albany, New York 12207-1002

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