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Elder Law Attorney

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of the New York State Bar Association

Message from the Chair

In our last newsletter, I informed you that our Section had approved a report prepared by Neil T. Rimsky and Elisabeth N. Radow on Governor Pataki's assisted living proposal. On January 25, 2001, Neil, Beth and I presented our Section's report to the New York State Bar Association Executive Committee. Our report was warmly received by the Executive Committee and approved as the NYSBA official position with respect to the assisted living proposal.

I further advised you that we planned to circulate the final report among New York State legislators with the hope of having a positive impact on the final bill. I am pleased to report that on February 27, 2001, I, along with Louis W. Pierro, Chair-Elect, Cora A. Alsante, Vice-Chair, and Ronald F. Kennedy, Associate Director of the Department of Governmental Relations of the NYSBA, spent the day in Albany visiting with various legislators. We met with Assemblywoman Ann Carrozza, Senator George Maziarz, Assemblywoman Deborah Glick, Chair of the Assembly Social Services Committee, Assemblyman Mark Weprin, Senator Raymond Meier, Chair of the Senate Social Services Committee, David Wollner, Assistant Director of State Operations for Health and Medicaid, and Susan Peerless from the Department of Health. In addition to discussing the assisted living proposal, we had the opportunity to discuss several other legislative proposals which emanated from the Elder Law Section and ultimately received NYSBA approval as affirmative legislative proposals.

Assembly 4198 and Senate 1441 are bills to amend the Social Services Law in relation to the treatment of income and resources of institutionalized persons. The Assembly version of this bill is sponsored by Mark Weprin and the Senate version of the bill is sponsored by Senator Skelos. The bill would modify the holding in the *Golf* case which held that the Department of Social Services (DSS) has the option of allocating income of the institutionalized spouse to the community spouse before allocating additional resources to the community spouse for the purpose of generating income up to the minimum monthly maintenance needs allowance (MMMNA) of $2,175. Of course, the playing field has been changed in light of the *Robbins* decision which held that with respect Social Security income, DSS is not permitted to mandate the income-first method. However, with respect to all other types of income, including pension and other retirement income, the community spouse is still at a disadvantage since she can not utilize the resources-first method. Accordingly, the bill would require DSS to utilize the resources-first method by computing the community spouse's

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income without taking into account the institutionalized spouse's income.

Assembly Bill 4197 sponsored by Mark Weprin and Senate Bill 79 sponsored by Senator Skelos would amend the Social Services Law to restore the family court's discretion to award support to community spouses of institutionalized Medicaid recipients based on the actual circumstances of the parties. This bill would reverse the holding of the *Gomprecht* case. The proposal would amend the Social Services Law by defining the community spouse monthly income allowance as an amount which may include the amount of support ordered by family court in its discretion having due regard to the circumstances of the parties in an amount greater than the amount that could be awarded at a fair hearing under the exceptional circumstances standard. It would allow family court judges to once again determine questions of support between spouses of nursing home residents based on more traditional standards of support, including standard of living and other expenses of the community spouse.

The next affirmative legislative proposal relates to the right of election. We are proposing to amend the Social Services Law so that the period of ineligibility for Medicaid institutional benefits resulting from a waiver of the right of election begins on the date which the waiver was signed, rather than on the date of the community spouse's death. This would overrule the result obtained in the *Dionisio* case where the Court held that the effective date of the waiver was the date of the community spouse's death. This Bill has been introduced in the Assembly by Mark Weprin as A.7016. At this time we are seeking a sponsor for the Bill in the Senate.

There are two other issues which the Elder Law Section is currently monitoring as they pertain to legislative activity in Albany. First, there is a bill to overrule the *Rodriquez* decision which held that safety monitoring could not be considered a task for purposes of computing the assessment of the number of hours of home care to be awarded. In addition, we are looking into the issue of banks and other financial institutions not honoring powers of attorney. We are working on legislation which would impose financial damages on institutions that did not honor a statutory short form power of attorney. As you can see we, have been quite active in the legislative arena and are hopeful that some or all of out efforts will be fruitful. The process of educating legislators is a long one and oftentimes can take many years from the time a Bill is originally introduced until the time it becomes law. However, we are hopeful that these Bills will ultimately be passed into law and will improve the quality of life of our clients.

Bernard A. Krooks

Editor's Message

I am pleased to present to you the 2001 Spring edition of the *Elder Law Attorney*.

Elder law attorneys have gotten a bad rap. Often we have been labeled as mere "Medicaid attorneys" who are simply out to sell the client on "hiding assets" so that vast fortunes can be protected from nursing homes. We and our clients know better.

Elder law is not a specific area of the law, but rather a practice focused on the varied needs of part of our population, the elderly. Whether their needs are health care, housing, public benefits, insurance, neglect and abuse, death and dying, grandparent rights, tax, incapacity, or many others, we elder law attorneys are there to help. Just look at the various elder law news articles within this edition as proof of the broad range of issues facing our clients. If you will notice, the topic of Medicaid is but a small piece of the information provided and indeed, a small piece of the needs and questions of our clients. I wish to, once again, thank our regular writers for their excellent and timely contributions.

One group who, either overtly or covertly, have tried to label us something we are not, is the insurance industry. It is believed by some that the insurance industry would like Medicaid Planning to go away because they feel they might sell more long term care insurance policies. Whether this is true of the insurance industry is not the point. What is true is that our perceptions of them and their perceptions of us have got to change.

The truth is that elder law attorneys are big supporters of the insurance industry. We approve of the vast strides they have made in improving products for our clients and we recommend these products every day. In my office, we recommend long-term care insurance to every client who walks in the door, provided they can afford it and are healthy enough to get it. I also believe that children should assist their working and middle class parents with the premium payments. Medicaid planning is a last resort but often a necessary one.

The bottom line is that the elder law and insurance communities must strive to improve our partnership for the betterment of our clients and our practices. We share many common goals. We can not continue pointing fingers at each other. We can learn from each other and approach problems through a team approach. Perhaps a joint conference in the future would prove helpful.

It is with this all in mind that I dedicate this 2001 Spring edition of the *Elder Law Attorney* to Insurance Issues.

The lead article contains an update on long-term care insurance by Bruce Reinoso.

The second article concerns life settlements of life insurance polices by Jack Sinclair. This article will help us understand how our clients can tap the death benefit of their life insurance policies during their lives. In this sense, we share a common goal with the insurance industry of improving the quality of lives of our mutual clients.

The third article, written by Mayur Dalal, is about values-based planning and the role of life insurance in this planning. The purpose of this article is to articulate that certain planners have changed the paradigm of planning to one based on values. We have a lot to learn from Mr. Dalal who makes the point that we need to get to know our clients a little better to find out what really is important to them.

The fourth article is written by our own tax guru, Stephen J. Silverberg, who discusses the ongoing marriage of life insurance and trusts. The irrevocable life insurance trust (ILIT) remains a great planning tool for our clients and is a great example of the need of elder law attorneys and insurance agents to work together.

The last article is written by one of Mass Mutual's biggest producers in the country, Fredric Laffie, who is forthright in his approach to life insurance illustrations. We all know that life insurance is a very important tool to provide estate liquidity and estate tax financing. But trying to compare one illustration with another is sometimes an admittedly daunting task. Fred points this out and urges us to be aware that sometimes such illustrations are illusions. This honesty is refreshing and opens the door for honest dialogue to the benefit of our mutual clients.

I hope you enjoy reading this edition of our journal. It was fun to work on.

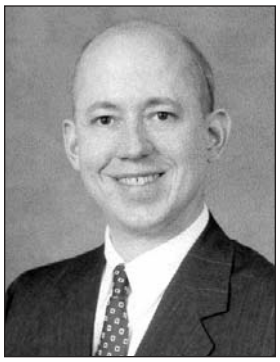
All my best! Keep smiling!

Lawrence Eric Davidow, CELA

Long-Term Care Insurance: Choosing the Right Policy and Avoiding Pitfalls

By Bruce D. Reinoso

Introduction



This article concerns long-term care insurance,[1] as distinguished from nursing home only insurance, home care only insurance, and nursing home and home care insurance.[2] The reader is assumed to be generally familiar with New York State Partnership and non-Partnership long-term care insurance policies, the mechanics of Partnership policies and Medicaid eligibility.

Clients considering the purchase of long-term care insurance should answer two questions. First, is it worth it? Second, can they afford it? The answer to the first question depends upon whether clients have sufficient resources to purchase long-term care without third-party assistance and assets they wish to protect from the cost of any long-term care they may require. The answer to the second question depends upon whether clients have sufficient income to make their co-payments, and the extent to which clients are willing to make up for insufficient income by using part of the principal they are protecting from depletion through purchase of long-term care insurance.

Whether clients can afford long-term care insurance also depends upon the scope of coverage they need and want. This article reviews policy features clients should consider when putting together a package of long-term care insurance benefits that fits their individual needs and wishes. Section One discusses policy features in general and applies for the most part to Partnership and non-Partnership policies. Section Two discusses some of the issues affecting the decision whether to purchase a Partnership or non-Partnership policy. Section Three discusses taxation of long-term care insurance policies.

Choosing the Right Policy

Benefit Options and Coverage

Choosing an LTC insurance policy requires putting together a benefit package tailored to the needs of the individual client. There are some benefit options and policy features upon which clients should not compromise, and others that require cost-benefit analysis. The following paragraphs highlight some of these features and raise questions clients must answer. Except as otherwise noted, these remarks apply to Partnership and non-Partnership policies.

Essential Features

Most of the benefit options characterized in this article as essential features must be in all long-term care insurance policies sold in New York. Policies should nevertheless be checked to determine whether they comply with the law. Some policies may include conditions that do not violate the law but effectively limit or restrict benefits based on level of care required or received.

Some of the benefit options characterized in this article as essential features need only be offered to clients at the time of application. Clients should be encouraged to accept such offers and include these "optional" benefits in their policies.

Premiums and Renewability

Policies must be guaranteed renewable and provide a level premium that can be raised only if it is raised for everyone in the same class.[3] This essential feature is mandatory for Partnership policies and non-Partnership policies.

Premiums vary depending upon the policy features selected by clients and their age at time of application. Premiums are generally higher for older clients and greater coverage. Premiums are affected by frequency of payment. Premiums are lower if paid annually rather than quarterly or monthly. Some companies offer payment options where large premiums are paid for relatively few years (e.g., a policy is "paid up" after five or ten years).

Most companies offer several premium discounts based on various factors such as marital, weight and smoking status.

Inflation Protection

Policies should provide automatic inflation protection that periodically increases the daily benefit. There should be no "proof of insurability" require-

ment for each increase in the daily benefit. A proof of insurability requirement is one that requires some degree of medical underwriting prior to approval. This essential feature is mandatory for Partnership policies (unless the applicant is over age 80) and optional for non-Partnership policies.[4]

The inflation protection feature should increase the daily benefit by at least 5% each year on a compounding basis. Partnership policies are required by law to include this feature.[5] Some insurers offer policies with inflation protection tied to the consumer price index. Whether a fixed or adjustable inflation feature is selected, it is possible that neither will keep pace with the actual rate of inflation for long-term care. Clients should have income and resources adequate to cover any resulting shortfall.

Some non-Partnership policies include optional, rather than automatic, inflation protection where the company periodically offers to increase the daily benefit. Clients purchasing such policies should understand how and when their option to purchase inflation protection can be exercised. Preference should be given to policies that do not impose proof of insurability requirements on the optional inflation protection, even though such requirements are permissible in certain circumstances.[6]

Automatic inflation protection generally increases the price of non-Partnership policies by approximately 25 to 33 percent. Cost-conscious clients sensitive to premium amounts who are considering no inflation protection, or simple rather than compound increases, may benefit from an illustration comparing: (i) growth over time of their desired daily benefit on a simple and compound basis; with (ii) inflation of the daily rate for long-term care.

Continuum of Care

Policies should provide benefits across a range of care including adult day care, respite care, home health care, nursing home care and "ALC" care (days spent in a hospital waiting for long-term care placement). This essential feature is mandatory for Partnership policies and optional for non-Partnership policies.[7]

Policies should not include a "prior level of care" requirement such as a hospital stay before payment of nursing home benefits, or a nursing home stay before payment of home benefits. This essential feature is mandatory for all long-term care insurance policies.[8]

Policies should not limit coverage to services provided by registered nurses, licensed practical nurses or Medicare-certified agencies or providers, or require that a nurse or therapist provide services that can be appropriately provided by a licensed or certified home health aide or worker. This essential feature is mandatory for all long-term care insurance policies.[9]

Case Management

Policies should provide case management coordinating LTC insurance benefits with other insurance benefits for which clients are eligible (i.e., Medicare and Employee Group Health Plans).

Pre-Existing Conditions

Policies should look back no more than six months for pre-existing conditions or diseases. The exclusion period for any pre-existing condition should be no more than six months following the date upon which the policy takes effect. Alzheimer's disease and other organic brain diseases should not be excluded from coverage. This essential feature is mandatory for all long-term care insurance policies.[10]

There is a distinction between exclusions from coverage and denial of applications for LTC insurance. Insurers can deny applications submitted by clients suffering from conditions at the time of application even though coverage for such conditions cannot be excluded (at least for more than six months) once a policy is in force.

Policies can exclude coverage for illness, treatment or medical condition arising out of various circumstances including, for example, war, criminal activity, suicide or self-afflicted injury, certain aviation, and while the insured is outside of the United States.[11]

More importantly, policies can exclude coverage for treatment provided in a government facility; covered by benefits under government programs such as Medicare, but not Medicaid; covered by workers' compensation; covered by mandatory motor vehicle no-fault law; or provided by family members or for which there is normally no charge in the absence of insurance.[12]

Flexible Features

Daily Benefit

The amount generally discussed is the daily benefit payable for nursing home care. It is equally important to select an adequate daily benefit for home health care, hospice care, adult day care and respite care.

Whether clients choose a Partnership or non-Partnership policy, the main reasons for buying long-term care insurance are obtaining independent access to long-term care, maintaining control over finances and living arrangements, and protecting assets. These reasons should be given greater weight than premium cost when selecting a daily benefit amount.

To avoid undesirable depletion of their assets, clients should select a daily benefit high enough that they can afford to make co-payments from their income. Some clients do not mind using a small percentage of their resources to make up any shortfall due to insufficient income.

By way of example, if the daily benefit is $148/day ($54,020/year) and the cost of care is $200/day ($73,000/year), the co-payment will be $52/day (or $18,980/year)! Alternatively, if the clients' daily benefit is $175/day and the cost of care is $200/day, the co-payment will be only $25/day (or $9,125/year).

Benefit Period

Choosing a benefit level depends upon whether your clients purchase Partnership or non-Partnership insurance.

Clients choosing Partnership insurance should buy no more than required for extended Medicaid eligibility. Present law requires clients to buy Partnership policies with a three year "bank of days." Once this bank of days is exhausted, clients insured under Partnership policies can apply for Medicaid. Clients should not buy Partnership insurance if they are not interested in becoming Medicaid recipients.

Clients choosing non-Partnership insurance should buy enough to meet their reasonably expected long-term care needs. At the very least, they should purchase a benefit period long enough that any asset transfers they choose to make will be outside the Medicaid "look-back" period.

Bed Hold

This feature pays the nursing home to hold clients' beds in the event they are hospitalized for a short period of time. Without a bed hold benefit, or enough money to reserve the bed out-of-pocket, clients risk being unable to return to the nursing home of their choice after a hospital stay.

Premium Waivers

This feature releases clients from the obligation of paying premiums once they begin receiving benefits under the policy. Most premium waivers begin on day 91 of a period of care. Some policies offer premium waiver from day one. Case-by-case calculation is required to determine whether this feature saves money for clients.

Non-Forfeiture Benefits

This feature provides some level of protection in the event of a default on premium payments. Such benefits may take the form of a shortened benefit period, conversion to a limited policy or refund of premiums paid upon the insured person's death. Clients must be given the option to purchase a non-forfeiture benefit.[13]

For example, some policies provide for the refund of a specified percentage of the premiums paid by clients, less any benefits paid by the insurer, after the policies have been in force for at least five years. These percentages must appear in the policy; they may be changed based on experience if changed in conjunction with a premium increase.[14] As discussed below, some non-forfeiture options may have income tax consequences.

Clients concerned about non-forfeiture benefits should examine this concern. If they suspect they will be unable to pay their premiums and daily co-payments, they should carefully calculate whether they can afford long-term care insurance. Traditional Medicaid planning may be more appropriate for these clients.

If eligibility for benefits begins while a policy is in force, payment of policy benefits may be extended, notwithstanding policy termination, so long as the reason for such eligibility continues without interruption. Insurers may limit such extension to the maximum benefit period or amount available if the policy continued in force. Extension of home care benefits may be capped at 12 months. Insurers may subject benefit extension to all waiting periods and other applicable provision of the terminated policy.[15]

Policies may be converted or continued by dependents of named insureds, and by insureds covered under group policies. The availability of conversion rights depends upon the basis for termination and satisfaction of conditions imposed upon applications for conversion or continuation.[16]

Exclusions, Restrictions and Waiting Periods

Underwriting

Insurers can reject applications for long-term care on the basis of medical underwriting. Different insurers have different thresholds, so clients rejected by

one company should submit applications to other companies. In some cases, an insurer may underwrite a fairly bad risk if the application comes through an agent who has sold a lot of policies to people the insurer considers to be good risks.

The following illustrative list sets forth some of the medical conditions likely to result in application rejection: Alzheimer's disease; liver cirrhosis; metastatic cancer; multiple strokes; muscular dystrophy; or Parkinson's disease.

The following illustrative list sets forth some of the medical conditions that may result in application rejection: alcoholism; arthritis; depression; diabetes; emphysema; epilepsy; heart surgery; high blood pressure; Hodgkin's disease; leukemia; lymphoma; mental illness; osteoporosis; paralysis; or spine injury.

Post-claims underwriting is prohibited and insurers cannot rescind policies if, based on medical information included in the application, the insurer knew or should have known at the time of the application of the existence of a medical condition for which coverage would have been denied. Insurers may rescind policies if clients fail to include all material medical information requested.[17]

Elimination Periods

LTC insurance policies include an elimination period during which no benefits are available to cover the cost of long-term care. This elimination period is roughly analogous to the deductible for a homeowner's policy. Clients can choose the length of their elimination period just like they can choose the size of their homeowner's deductible.

Most LTC policies have a separate elimination period for each period of care. Some policies have only one elimination period for the life of the policy. All else being equal, a single elimination period is preferable to multiple elimination periods. Clients considering policies offering a single elimination must balance the cost of this feature (i.e., increased premium) against the savings (i.e., a lower "deductible").

For Partnership policies, two periods of care must be separated by more than six months to be considered separate periods of care.[18] For non-Partnership policies, two periods of care must be separated by at least thirty days of nonpayment of benefits to be considered separate periods of care.[19]

Selecting an elimination period requires balancing the higher premium cost for a shorter elimination period against the expense of paying out-of-pocket during a longer elimination period. For example, if nursing home care costs $200/day, a 100-day elimination period will cost $20,000! A 20-day elimination period will cost $4,000. Depending upon the company, a shorter elimination period can increase the premium anywhere from ten to 25 percent. It could take years for the additional premium cost of a 20-day elimination period to approach the out-of-pocket expense incurred as the result of choosing a 100-day elimination period.

Another reason to select a short elimination period is that some statistics suggest that most nursing home stays last three months or less.

When comparing policies, check to see if there are different elimination periods for different levels of care (i.e., nursing home care and home care). Partnership policies are permitted only one elimination period for all covered services, per period of care.[20]

When comparing policies, determine whether the policy uses a calendar-day or a service-day based method for determining when the elimination period has expired. The elimination period for policies using a calendar-day method is reduced by each day on which covered services are received. The elimination period for policies using the service-day method is not reduced unless clients receive at least the specified minimum number of hours and/or combination of services defined by the policy to constitute a service day.

When comparing policies determine whether the policy permits exhaustion of the elimination period by accumulation of days within a specified time period (e.g., any 100 days within one 180-day period) or if the elimination period requirement is satisfied by only consecutive days.

Activities of Daily Living

Most LTC policies will not pay nursing home or home health care benefits unless clients are unable to perform two of five activities of daily living (ADLs) and are not expected to regain that functional ability within a specified time period. Cognitive impairment requiring substantial supervision generally satisfies the ADL threshold of most policies.

Partnership v. Traditional

In theory, Partnership policies allow clients to share the cost of their long-term care with New York State. If one partner purchases LTC insurance equal in amount to a three-year "bank of days," the other partner offers "extended" Medicaid eligibility based

solely upon income and without regard to resources possessed or transferred.

Baseline Partnership policies include the features described above as those upon which clients should not compromise.[21] Insurers are permitted to offer Partnership policies which exceed the basic minimum coverage.[22] For a higher premium, clients may enhance baseline Partnership policies with a higher daily benefit and shorter elimination period. At the very least clients should consider increasing the daily benefit above the minimum required by law since it generally is unrealistically low in comparison to the actual cost of long-term care.

Client Objectives

The choice between Partnership and non-Partnership policies should be based on individual goals and priorities.

Some clients primarily wish to shelter their assets from the cost of any long-term care they may require. These clients may prefer to purchase Partnership policies. Partnership policies allow clients to purchase a certain, minimum amount of coverage with the expectation that they will be eligible for Medicaid once their insurance coverage is exhausted. This expectation is reasonable only if the clients' income will not exceed Medicaid eligibility requirements regarding income.

Other clients primarily wish to have sufficient means to buy the kind of long-term care they want, where and when they want it. These clients may prefer to purchase non-Partnership policies. Non-Partnership policies also protect assets from Medicaid so long as clients buy sufficient coverage to obviate the need for Medicaid, or at least wait out any applicable "look-back" period before applying for Medicaid. How much coverage is sufficient depends upon clients' health and income expectations.

Long-term care insurance may make sense for clients who can afford to pay out-of-pocket for the entire cost of long-term care. Whether these clients buy long-term care insurance depends on their risk tolerance. They must balance the risk of paying nothing for long-term care insurance and needing years of nursing home care (at $70,000/year) against the risk of paying $5,000-$10,000/year for long-term care insurance and needing only a few weeks of home health care. These clients must decide whether it is more likely they will need expensive care for a long period of time or inexpensive care for a short period of time.

Advantages

The primary advantage to Partnership policies is that clients need purchase no more than a specific minimum length of coverage. Clients who become partners with New York State need purchase only a three-year "bank of days."

Clients who purchase non-Partnership policies must carefully choose the length of coverage and purchase an amount reasonably expected to be adequate to meet their needs. This could require purchase of more than the minimum length of coverage required for Partnership policies. Failing to purchase sufficient coverage may leave clients in need of Medicaid and all of their assets exposed.

Partnership policies are required to include an arbitration provision. This requirement is designed to help insureds win coverage for claims denied by the insurer. This requirement, concomitantly, increases the likelihood that the insurer will have to pay claims. As a result, insurers may raise their Partnership premiums to compensate for the increased risk attributable to the required arbitration provision. Be sure clients know about this provision and how to use it.

Disadvantages

There are several disadvantages to New York State Partnership policies. Some of these disadvantages are tangible and can be weighed against the advantages. Others are intangible and not easily balanced. For example:

Premiums

Premiums for New York State Partnership policies are generally higher than premiums for non-Partnership policies with similar benefits. This difference between Partnership and non-Partnership premiums varies from one insurer to the next and can range from ten to 25 percent. One reason for this difference may be the arbitration provision discussed above.

Location

Although clients can receive Partnership insurance benefits in any state, they must return to New York after exhausting their three-year "bank of days" because Medicaid eligibility is state-specific.[23]

Home Care

One significant disadvantage to Partnership policies is that they generally pay only 50% of the daily

benefit when clients are receiving home health care. It is not difficult to imagine scenarios where the home care needed may require delivery by a skilled medical professional such as a nurse or physical therapist. In such situations, or if home care is needed 24 hours per day, home care bills could approach or exceed the cost of full time care in a nursing home.

Some Partnership policies pay less than 50% of the daily benefit selected by clients for nursing home care. For example, some insurers pay only 80% of the charge for custodial care, so to receive the full 50% of the daily benefit clients may have to receive home care services for which the charge is 120% of the daily benefit. Some insurers will pay for only certain levels of care.

One selling point of some non-Partnership policies is the fact that they can be structured to pay 80% or even 100% of the daily benefit regardless whether they receive the care at home or in a nursing home. Some Partnership policies offer two pools of money, one for home health care and one for nursing home care, and will let clients use the nursing home pool to pay home health care costs once the home health care pool is exhausted.

Balancing Factors

The following factors may be help clients weigh the advantages and disadvantages of Partnership insurance coverage of home health care.

Risk Tolerance

Factoring the advantages and disadvantages of Partnership policies into client's policy-selection process requires assessing their risk-tolerance as well as performing a cost-benefit analysis.

Are clients willing to bet that they are more likely to require nursing home care? If clients need home health care instead, can they afford to pay 50% (or more depending upon the daily benefit selected) of the cost? If the cost of home care equals 100% of the daily benefit (e.g., $148/day), the co-payment would be $74/day and clients might have to pay it for up to six years. That comes to $27,010/year for a total of $162,060 over six years!

Medicaid Eligibility

The disadvantages of Partnership policies may be balanced by the fact that Medicaid eligibility will be calculated without regard to resources once clients have exhausted their three-year "bank of days."

With non-Partnership policies, clients are on their own once they exhaust their benefits, and if clients must apply for Medicaid their eligibility will be affected by the resources they possess or transfer.

The uncertain future of the Medicaid program is cause for concern. Determining how much weight to assign this concern in clients' policy-selection process is difficult. It appears inevitable that New York's generous Medicaid program is going to be scaled back, but it is impossible to say now what shape the program will take in the future.

Informal Caregivers

Another factor that affects this analysis is the availability of informal caregivers. As a general rule, clients receiving home health care must have relatives and friends who can be relied upon to provide a great deal of care on a continuous, daily basis. Clients who do not have informal caregivers usually must live in nursing homes or adult care facilities.

Clients whose good health and sound finances permit them to live in adult care facilities can generally receive home health care without informal caregivers because of their living arrangement.

Clients with no informal caregivers, and whose goal is asset protection, probably should balance these factors in favor of a policy that emphasizes nursing home care rather than home care. Clients who reasonably can count on the support of informal caregivers, and whose primary goal is flexibility and control over their living arrangements, probably should balance these factors in favor of a policy that emphasizes home care as well as adequate nursing home benefits.

Individual Choice and Compromise

Clients should select a package of benefits that fits their personal needs. Clients must decide which features are most important based on their health and financial condition.

Clients may have to compromise on one desirable feature so they can obtain another feature more important given their individual circumstances. For example, a policy that pays only 50% of the daily benefit towards the cost of home health care may waive premium payment starting on the first day of benefit payments. Another policy may have a higher premium but pay up to 100% of the daily benefit towards the cost of home health care.

Taxation

Treatment of Long-Term Care Insurance

Federal and state tax law include incentives for purchasing long-term care insurance.

Qualified long-term care insurance is treated as accident and health insurance for purposes of the Internal Revenue Code. This includes an individually purchased contract as well as one provided under an employer plan.[24]

Amounts received under a qualified long-term care insurance contract (other than policyholder dividends and premium refunds) are generally excludable from gross income as amounts received for personal injuries and sickness.[25]

Amounts paid for a qualified long-term care insurance contract are treated as payments made for insurance and are, to some extent, deductible as medical care expenses.[26] Premium refunds upon death of the insured or complete cancellation of the policy are includable in gross income to the extent any deduction or exclusion was allowed.[27]

Qualified Long-Term Care Insurance Contracts

To be eligible for the tax treatment described above, the long-term care insurance policy must be a qualified long-term care insurance contract.

A qualified long-term care insurance contract is guaranteed renewable and provides coverage for only qualified long-term care services. It does not provide coverage for services or items covered by Medicare as primary payor (or which would be covered but for application of a deductible or coinsurance amount). A long-term care insurance policy is not disqualified if its benefits are coordinated with Medicare.[28]

A qualified long-term care insurance contract does not provide cash surrender or other money that can be paid, assigned, borrowed or pledged as collateral for a loan. Policyholder dividends and premium refunds must be applied to reduce future premiums or increase future benefits. An exception is made for premium refunds upon death of the insured or complete cancellation of the contract. Refunds covered by this exception cannot exceed the aggregate amount paid for the policy and are includable in gross income to the extent any deduction or exclusion was allowed.[29]

A qualified long-term care insurance contract must satisfy consumer protections requirements described below.[30]

A long-term care insurance policy is not a qualified long-term care insurance contract unless the determination of whether an individual is a chronically ill individual takes into account at least five of the six activities of daily living (eating, toileting, transferring, bathing, dressing and continence).[31]

Qualified Long-Term Care Services

Qualified long-term care services are necessary services required by a chronically ill individual and provided pursuant to a plan of care prescribed by a licensed health care practitioner. These services include diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services.[32]

A chronically ill individual is someone who has been certified by a licensed health care practitioner as either being unable to perform without substantial assistance at least two activities of daily living for at least ninety days, or requiring substantial supervision to protect against threats to health and safety due to severe cognitive impairment.[33]

Qualified long-term care expenses are deductible if not reimbursed by long-term care insurance, or otherwise.[34]

Aggregate Payments in Excess of Limits

Periodic payments received for any time period by an insured under any qualified long-term care insurance contract(s) are generally excludable from gross income unless the aggregate of periodic payments received for qualified long-term care services and by reason of the insured's death (not counting payments received at the time the insured is terminally ill) exceeds the per diem limitation for that period.[35]

The per diem limitation for any time period is the greater of a statutorily stated dollar amount or the costs incurred for qualified long-term care services during that time period over the aggregate payments received as reimbursement for qualified long-term care services provided to the insured during that time period, through insurance or otherwise.[36] Payments exceeding the per diem limitation are excludable from gross income to the extent of actual costs incurred for qualified long-term care services, and includable to the extent costs were not incurred.

For calendar year 2001, the stated dollar amount of the per diem limitation is $200.[37]

Eligible Long-Term Care Premiums

Amounts paid during a taxable year for any qualified long-term care insurance contract ("eligible long-term care premiums") may be deductible for federal income tax purposes as expenses paid for medical care. No deduction is allowed for medical expenses, except to the extent they exceed 7.5 percent of adjusted gross income. Even after this initial threshold is satisfied, the dollar amount deductible is limited according to the tax payer's attained age before the close of the taxable year.[38]

For tax years beginning in 2001, the limitations are as follows:

Attained Age	Limitation
40 or less	$230
More than 40 but not more than 50	$430
More than 50 but not more than 60	$860
More than 60 but not more than 70	$2,290
More than 70	$2,860[39]

Consumer Protections

One important advantage of a qualified long-term care insurance contract, besides preferential tax treatment, is that it contains the features described in this article as essential and desirable. A qualified long-term care insurance contract must satisfy consumer protections requirements related to guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, disclosure, prohibitions against post-claims underwriting, minimum standards, inflation protection, prohibitions against pre-existing conditions exclusions and probationary periods, and prior hospitalization.[40]

Additional consumer protections are provided by requirements related to application forms and replacement coverage, reporting requirements, filing requirements for marketing, standards for marketing, appropriateness of recommended purchase, standard format outline of coverage, delivery of a shopper's guide, right to return, outline of coverage, certificates under group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period.[41]

The consumer protection provisions set forth in the final regulations apply to contracts issued after December 10, 1999. Taxpayers may rely on IRS Notice 97-31 with respect to contracts issued before that date. Contracts issued on or before that date will be treated as qualified long-term care insurance contracts if they satisfy the requirements of the final regulations.[42]

Grandfathered Contracts

A pre-1997 long-term care insurance contract is treated as a qualified long-term care insurance contract regardless whether it satisfies 26 U.S.C. § 7702B and regulations thereunder, unless it has been changed in a way deemed to constitute issuance of a new contract.[43]

A pre-1997 long-term care insurance contract is any long-term care insurance policy with an issue date before January 1, 1997 that met the long-term care insurance requirements of the state in which the contract was issued on the issue date.[44]

Changes treated as issuance of a new contract include altering the amount or timing of an item payable by either the policyholder (or certificate holder), the insured, or the insurance company, substitution of the insured under an individual contract or changing eligibility terms for membership in the group covered under a group contract. Exceptions are made a policyholder's exercise of any right provided under the terms of the contract as in effect on December 31, 1996, or a right required by applicable state law to be provided to the policyholder; a change in the mode of premium payment (e.g., from monthly to quarterly premiums); a classwide premium change for a guaranteed renewable or noncancellable policy; a premium reduction due to the purchase of a long-term care insurance contract by a family member of the policyholder; a reduction in coverage (with a corresponding premium reduction) made at the request of a policyholder; a premium reduction as a result of extending to an individual policyholder a discount applicable to similar categories of individuals pursuant to a premium rate structure that was in effect on December 31, 1996, for the issuer's pre-1997 long-term care insurance contracts of the same type; addition, without premium increase, of alternative forms of benefits that may be selected by the policyholder; addition of a rider or amendment which, if issued as a separate contract of insurance, would be a qualified long-term care insurance contract; deletion of a rider or contract provision prohibiting coordination of benefits with Medicare; effectuation of a continuation or conversion of coverage right provided under a pre-1997 group contract that, in accordance with the terms of the contract as in effect on December 31, 1996, provides for coverage under an individual contract fol-

lowing an individual's ineligibility for continued coverage under the group contract; and substitution of one insurer for another in an assumption reinsurance transaction.[45]

The final regulations applicable to pre-1997 long-term care insurance contracts became effective January 1, 1999. Taxpayers may rely on IRS Notice 97-31 regarding whether a change made before January 1, 1999 to a pre-1997 long-term care insurance contract constitutes issuance of a new contract. Contracts issued on or before that date will be treated as qualified long-term care insurance contracts if they satisfy the requirements of the final regulations.[46]

Alternatives

Younger clients who are disciplined investors might consider implementing a "long-term care" investment strategy, such as investing an amount each year equal to the average annual premium paid by actuarially similar individuals. Depending upon investment and tax results, these clients could accumulate an asset equal to or greater than the maximum coverage amount available under a long-term care insurance policy. Unlike the insurance coverage, the asset would be available to these clients without having to sustain a covered loss and obtain covered services from approved providers.

Older clients with adequate resources might consider purchasing life insurance, possibly outside their taxable estate in an irrevocable life insurance trust, instead of long-term care insurance. The life insurance death benefits could replace assets consumed by the cost of any long-term care incurred by these clients, and increase the wealth transferred upon their death.

Existing life insurance policies can provide living benefits rather than death benefits. The issuing insurer may offer accelerated benefits. Viatical companies will buy policies. In both cases, clients receive a discounted present value for the death benefit, which is then made payable to the insurer or viatical company. These living benefits may be subject to income tax and affect Medicaid eligibility.

Conclusion

Planning for the cost of long-term care is as important as estate planning. Long-term care insurance can be a valuable part of a long-term care plan. Clients should buy long-term care insurance only if they have enough assets to protect and enough income to pay premiums and co-payments. Clients who cannot afford long-term care insurance probably should consider "traditional" Medicaid planning. Clients who can afford long-term care insurance must decide how much coverage to buy and choose between Partnership and non-Partnership policies.

Deciding how much coverage to buy requires analysis of each client's objectives, finances and medical condition. Some benefit options, such as automatic inflation protection and broad coverage across a continuum of care, are essential features every policy should include. Other benefit options, such as daily benefit amount, elimination period length and premium waivers, are policy features subject to cost-benefit analysis.

Deciding whether to buy Partnership or non-Partnership insurance depends, first, upon whether clients will meet the "extended" Medicaid eligibility requirements upon exhaustion of their Partnership coverage. Clients should also consider whether they are comfortable with the uncertain future of Medicaid and the scope of benefits offered by New York. Other factors affecting the choice between Partnership and non-Partnership policies include client objectives and reasonably anticipated medical needs. Clients choosing Partnership policies may be forced to relinquish an undesirable amount of personal autonomy once they exhaust their insurance and make the switch to Medicaid. Clients choosing non-Partnership policies will pay more to retain their personal autonomy and must be careful to purchase enough coverage.

Whether clients purchase Partnership or non-Partnership policies, the decision to buy long-term care insurance requires case-by-case analysis of their circumstances and careful balancing of priorities. The reward for such effort is a carefully considered long-term care plan that will improve the lives of your clients.

Endnotes

1. 11 N.Y.C.R.R. § 52.12.
2. 11 N.Y.C.R.R. § 52.13.
3. 11 N.Y.C.R.R. § 52.25(b).
4. 11 N.Y.C.R.R. §§ 39.3(b)(5), 52.25(c)(3).
5. 11 N.Y.C.R.R. § 39.3(b)(5).
6. 11 N.Y.C.R.R. § 52.25(c)(3).
7. 11 N.Y.C.R.R. § 39.3(b).
8. 11 N.Y.C.R.R. § 52.25(c)(1).

9. 11 N.Y.C.R.R. § 52.25(c).
10. 11 N.Y.C.R.R. § 52.25(b)(2).
11. *Id*.
12. *Id*.
13. 11 N.Y.C.R.R. § 52.25(c)(7).
14. 11 N.Y.C.R.R. § 52.25(c)(7).
15. 11 N.Y.C.R.R. § 52.25(b)(3).
16. 11 N.Y.C.R.R. § 52.25(b)(4).
17. 11 N.Y.C.R.R. § 52.25(d).
18. 11 N.Y.C.R.R. § 39.3(b)(9).
19. 11 N.Y.C.R.R. § 52.25(c)(9).
20. 11 N.Y.C.R.R. § 39.3(b)(9).
21. 11 N.Y.C.R.R. § 39.3(a).
22. *Id.*
23. 11 N.Y.C.R.R. § 39-3.
24. 26 U.S.C. § 7702B(a).
25. *Id.*
26. *Id.; see* 26 U.S.C. § 213(d).
27. 26 U.S.C. § 7702B(b); New York State Tax Law § 612(c)(31).
28. *Id.*
29. *Id.*
30. *Id.*
31. 26 U.S.C. § 7702B(c).
32. *Id.*
33. *Id.*
34. 26 U.S.C. § 213.
35. 26 U.S.C. § 7702B(d).
36. *Id.*
37. IRS Revenue Procedure 2001-13, § 3.27.
38. 26 U.S.C. § 213; N.Y.S. Tax Law § 612(c)(31).
39. IRS Revenue Procedure 2001-13, § 3.10.
40. 26 U.S.C. §§ 7702B(b)(1)(F), (g).
41. 26 U.S.C. § 4980C.
42. 26 C.F.R. § 1.7702B-1.
43. 26 C.F.R. § 1.7702B-2.
44. *Id.*
45. *Id.*
46. 26 C.F.R. § 1.7702B-2.

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The Life Settlement Transaction— A New Estate Planning Tool— Often Unknown and Frequently Misunderstood

By Jack V. Sinclair

The current value of a life insurance policy is generally considered to be the cash surrender value of the policy, however, in certain situations the true value may be significantly more. Even a term life insurance policy might have significant value. This is 21st century technology that provides the estate planner with a new cutting edge tool to determine when, and if, a life insurance policy is worth more than its book value. This is value added professional service.

This transaction, most commonly referred to as a Life Settlement, can be defined as the sale of an existing life insurance policy, for a percentage of its net death benefit, for immediate funds. Most transactions are made by older persons (70+) who no longer need, want or can afford their policies. However, this is also a valuable new tool in the business arena. The policy owner can actually turn a liability (premium) into an asset (cash). Life Settlements can enhance the financial and estate planning flexibility of an entire generation of emerging affluent seniors.[1]

Prior to inception of the Life Settlement transaction, the only choices available to someone for the disposition of a policy were to surrender it for its cash surrender value or, in the case of term insurance, let the policy lapse. Life Settlements bring about a redefinition of the whole notion of "cash value" for life insurance policies.[2]

If estate tax repeal becomes a reality, every estate planner should have a quality broker relationship in place to assist with the client's excess insurance issues.

How a Life Settlement Works

The overall concept of a Life Settlement is relatively simple: a policy owner agrees to sell his policy, for an agreed-upon sum of money, to a third-party funding company, who then becomes the new owner and beneficiary of the policy and assumes all future premium obligations.

Several factors play into the determination of fair market value of a policy. These are: 1) net death benefit of the policy; 2) age and health condition of the insured; 3) policy premiums; and 4) rating of the insurance carrier.

To receive policy appraisals, the policy owner completes a brief questionnaire consisting of pertinent personal and policy questions. Questionnaires include policy and medical releases for execution by the owner and the insured. These allow Life Settlement providers to access information for underwriting purposes.

"The policy owner can actually turn a liability (premium) into an asset (cash). Life Settlements can enhance the financial and estate planning flexibility of an entire generation of emerging affluent seniors."

When the funding company has all the pertinent information, they will then determine the value of the policy as a Life Settlement. The policy owner is never under any obligation to accept any offer presented. Once a policy owner accepts an offer, a set of closing documents will be sent for completion. These will include the purchase agreement, insurance company change forms, and various other information requests relevant to the sale of the policy. After the funding company receives the necessary signed documents, etc. they will forward the insurance company's Change of Ownership and Change of Beneficiary forms to them for execution. When the funding company receives verification that the changes have been executed, the settlement funds will be released.

Qualifying Factors

Individuals Considered

Individuals over the age of 70 will be considered. Individuals as young as 65 may qualify when they have significant health concerns.

Policies Considered

- Term life
- Universal Life
- Variable Life
- Group Life
- Survivorship Life

Ownership by:

- Individual
- Trust, or
- Corporation

Policy must be beyond contestable period (2+ years).

- Minimum face amount considered is $200,000.

Estate Planning Applications

There are many circumstances where selling an existing life insurance policy is in the best interest of the policy owner, however, the answer in its simplest form is that the policy is no longer wanted, needed or affordable. In greater detail, any of the following might apply:

- A client wants to remove the policy from a trust or estate.
- A reduction in estate value means less insurance is required for tax liability.
- A client has outlived his beneficiary(s) or those interests have changed.
- A client considers selling a life insurance policy to replace highly appreciated assets which were donated to charity.
- A policy is no longer needed, appropriate, or affordable due to changing circumstances.
- Due to changing circumstances:
  - a client needs to replace his individual policy with a survivorship policy.
  - a client's estate becomes liquid and the original coverage is no longer needed.
- A client has a need for long-term care or long-term care insurance, thus a policy may be sold to fund these new needs.
- A change in the client's financial condition makes the premiums too expensive.
- A client has a financial need that can be met by the sale of a life insurance policy.

Removing a Policy From an Estate

Under certain circumstances a Life Settlement may be the only means by which an insurance policy may be removed from an individual's estate. A Life Settlement can be a means of avoiding the three-year rule, thereby maximizing the proceeds to be transferred to the insured's family or other beneficiaries, and reducing estate taxes. Because a Life Settlement is a "sale for value" the three-year rule does not apply.

"There are many circumstances where selling an existing life insurance policy is in the best interest of the policy owner, however, the answer in its simplest form is that the policy is no longer wanted, needed or affordable."

Charitable Giving

It can be advantageous to donate highly appreciated assets to charity because the donor receives a current income tax deduction equal to the fair market value of the asset, rather than the donor's basis in the asset. Often, however, such assets are income producing (e.g., security, real estate) and the donor may not be able, or willing, to lose the income. As an alternative, proceeds obtained from a Life Settlement may replace such highly appreciated assets. The appreciated assets can then be gifted to charity to satisfy the donor's charitable goal of making a substantial lifetime gift.

Business Applications

A policy was purchased to finance a buy-sell agreement that is no longer needed after the business has been sold to a third party.

A key-man policy is no longer necessary because:

- the key-man has retired,
- the business has been sold,
- or the business has matured such that its fortunes are no longer dependent on one individual.

Bankruptcy

The sale of a policy owned by a corporation may be useful for satisfying the claims of creditors.[3]

A lender who received a policy as collateral after a default may want to sell the policy to get more money.[4]

Case Study

Mr. K was CEO of a large company that had two key-man life insurance policies on his life. One was a $500,000 universal life insurance policy with a cash surrender value of $34,000, while the other was a $500,000 term life insurance policy. As the company had carried the value of the UL policy on the books as the cash surrender value, they had planned to do a partial surrender of the policy to remove the cash value and then to offer both policies to Mr. K. Mr. K, having discussed the policies with a Life Settlement broker, was informed that the policies did have more value as a Life Settlement, so he purchased the UL policy from the company for it's cash surrender value. Mr. K then began working with the Life Settlement broker to acquire appraisals for his policies. In the end, he ended up selling the policies for $145,000.

Term Policy	**UL Policy**
$500,000 key-man policy	$500,000 key-man policy
$15,095 annual premium[5]	$11,820 annual premium
Settlement: $65,000	**Settlement: $80,000**

Net Return to Mr. K: $111,000

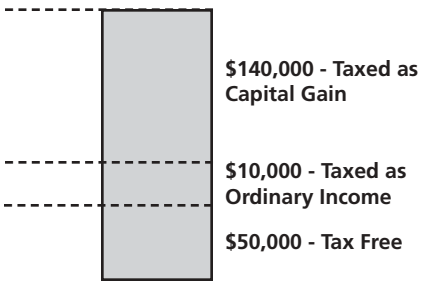
($145,000 less the $34,000 that Mr. K paid the company in reimbursement for the cash surrender value of the UL policy).

Tax Issues

Tax consequences from the transaction vary, but generally all Life Settlement funds that are less than the tax basis are received tax free, all funds received in excess of basis up to cash surrender value (CSV) are treated as ordinary income; funds in excess of CSV are treated as long term capital gain. Under certain conditions, the life settlement proceeds are tax free.[6]

For example:

- $1,000,000 life insurance policy
- $50,000 in premiums were paid into the policy
- At the time of sale, the policy had a cash surrender value of $60,000
- The policy is sold for $200,000



Other Issues to Consider

Proper disclosure to all parties of the Life Settlement is of paramount importance before consummating the purchase and sales agreement. These items include issues such as:

1. Exploring Other Alternatives
   - Would it be more beneficial to borrow against the cash value of the life insurance policy?
   - Would surrendering the policy be the best option?
   - Are accelerated death benefits available under the provisions of the policy?
2. Understanding the Tax Implications
   - Will the proceeds be taxed?
   - If so, in what manner?
3. Will the proceeds be subject to claims by creditors, personal representatives, trustees in bankruptcy and receivers in state and federal courts?
4. Will the receipt of the sale proceeds adversely affect eligibility for Medicaid, Social Security income or other government benefits?

Market Potential of Life Settlement Industry

Life Settlements include purchases of policies from seniors as well as from individuals of all ages suffering from terminal or chronic illnesses. Conning & Company has calculated the Life Settlement market at $108 billion over the next decade. This number was derived from market sampling to determine what percentage of senior policy owners are willing to sell.

Conning & Company researched the market of individual life insurance owned by the age 65 and higher population. With over $492 billion of insurance in force, this group represents the fastest growing and most affluent of the country's population. With extended life expectancies, the group assures continued demand for financial services that provide flexibility during retirement.

Life Settlement Broker

A good Life Settlement Broker will provide the customer support and industry knowledge that will make the process flow smoothly. A good Broker will also have contracts with Life Settlement providers/funders nationwide, enabling them to present you with the best offer for the policy. Experience and credibility are imperative when choosing a Life Settlement Broker to represent your client's best interests. References are essential, including the state department of insurance. Institutionally funded settlement companies with established bank relationships for providing fiduciary services are essential to this intermediary relationship.

Summary

In many cases, the sale of an existing life insurance policy may be a preferable means of disposing of the policy in comparison with lapse or surrender, particularly for senior citizens. Very few estate planning professionals are aware that such policies can be sold, but they need to know about the power and value of the Life Settlement transaction. Use of Life Settlements as an option in financial and estate planning services provides flexibility with life insurance heretofore unavailable. Many financial and estate planning service professionals deem it their fiduciary responsibility to apprise clients of options such as the Life Settlement option. We expect valuation and due diligence professions to incorporate this transaction into their planning practice.

Endnotes

1. Conning and Company, 1999.
2. Conning and Company, 1999.
3. Lawyers Weekly, USA, April 3, 2000.
4. Lawyers Weekly, USA, April 3, 2000.
5. The term life insurance policy was converted to a UL policy prior to the sale. Mr. K was still within the conversion privilege as outlined by his policy, which allowed for the policy to be converted to a UL product. There were no new medical exams required.
6. IRC § 101(g).

Jack V. Sinclair is a financial planning professional with more than 30 years of experience. He hold the following securities licences: Series 7, 24, 63 and 65. He is a partner in The Heritage Group, a licensed settlement broker that has processed over $100 million of settlement business since 1998. The Heritage Group also provides industry training and continuing education to the professional advisor industry. Jack is a 1970 graduate of the University of Oklahoma with a BS degree in Finance.

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Values-Based Planning and the Role of Insurance in Such Planning

By Mayur T. Dalal

Introduction

This article plans to help the reader explore the current process of planning and its inherent gaps. It will also help them understand how a holistic approach to planning, which integrates values transference with wealth, can lead to a long-lasting, high-trust relationship that will empower clients to make well-informed decisions on their life planning issues. Finally, this article will also give insights into the psychological determinants of decisionmaking. Once clients have made the decision on their wealth transfer, integration of advance planning tools with tax strategies and suitable insurance vehicles give them the ability to multiply their wealth transfer several fold to the next generation.

Discovery Process

Characteristics of the Golden Age Generation

This generation is currently 62-70 years old and has survived the great depression and World War II. They are frugal, caring, fair to their families and optimistic. They are also in great physical and mental health. Many of them are civic minded and give significant time to charities and volunteer for different causes. They are big savers and hence have accumulated significant wealth.

Substantial and exponentially growing affluence enjoyed by an increasing number of aging families raises the question of how to properly allocate wealth in light of death and taxes.

Parents' Wish List

1. Play mentoring role for their heirs
2. Help develop emotional and financial competencies in beneficiaries allowing them to manage large amounts of future inheritance.
3. Create a wealth transfer program that allows and encourages positive personal development.

Research Findings

There are several reasons why most of the senior clients start the process of planning but never finish:

1. Aging population gets overwhelmed with the complexity of the planning.
2. They always fear loss of control over the assets or business.
3. Confronting different opinions from different advisors; everybody looks at their perspective instead of clients.
4. Use of technical jargon by advisers leads to confusion.
5. Nobody wants to talk about dying and planning after death.
6. Transaction-driven business practices of the several service industry professionals. Result is client feels pressured to make decisions about the issues they do not understand.
7. They fear irrevocable separation of their wealth.

In the next 20 years these people will be responsible for a $10 trillion wealth transfer to the next generation. They are faced with many choices and therefore they need and want help to make wise decisions about wealth transfer.

Values-Based Planning

In 1996 we embarked upon a journey to become a value added resource to these clients. We created a mastermind group of people who made a big difference in our practice. Dan Sullivan, Scott Fithian and Bill Bachrach helped us develop this unique values based planning approach, "Wealth Transfer with Wisdom." Dr. Paul Schervish provided us with the enormous depth of his research study with the afflu-

ent. Several of our relationships that went through the process have transformed their lives from being successful to becoming significant. We have helped these valuable relationships live their life with renewed purpose.

As trusted advisor and family wealth coach we act as facilitator to help current and potential clients discover what is important to them, articulate their goals and benchmark where they are now.

We focus on our client's values. Values are those qualities and principles intrinsically valuable or desirable to them, have particular significance—the words they use to describe are life's emotional payoff.

Process

Our primary focus is to identify the values of these clients through interviews and structured questionnaires.

We help develop a family philosophy that becomes the guiding light for all advisors and an explanation of intentions for all family members.

We identify the gap between where they are and where they want to be within different life planning goals (financial, spiritual, personal, emotional, physical).

We create a financial vision and strategy customized to each client's situation, based on their risk tolerance, time horizon, and threshold for complexity; and then we integrate their values.

We then present choices to the client and help them make well informed and wise decisions so that they achieve what is important to them and reach their life planning goals.

Through this process a client is empowered to optimize their wealth transfer and may choose to multiply the legacy for next generation. A family mission statement and family retreat help them stay focused and reinforces their values transference on a regular basis to their family.

On an ongoing basis we are committed to excellence to create a positive experience for the clients. We conduct quarterly review meetings to monitor progress and help them stay on track.

Therefore values-based planning represents a different perspective on managing wealth than conventional wealth replacement strategies.

If you look at the big picture, money is not that important. It is significant only to the extent that it allows you to enjoy what is important to you. And not worrying about money is critical to having a life that excites you, nurtures those you love and fulfills your highest aspirations.

What will their life be like if they developed a financial strategy based on what was truly important to them, where their investment and insurance strategies were working in harmony to achieve their goals? This will be in stark contrast to what most people have, which is a strategy based on heterogeneous product selection purchased one at a time over years from various sales people and companies based on tips from friends or information brochures.

With the new administration coming in, one of the biggest fears some planners have is the repeal of estate taxes. With a proposed $1.6 trillion tax cut, the republican administration is likely to bring in sweeping changes in the tax laws. However, since we create value added in client relationships, tax issues become a small part of overall life planning.

Our clients are typically persons with a $10 million net worth and are independently wealthy. Due to our relentless commitment to make a difference in our clients' lives, we have converted the adversity of tax repeal into an opportunity. We have become our clients' wealth coach.

I would like to share a case with you where a client bought a large life insurance policy to multiply the gift several fold and did not make the decision on proposed tax law changes.

Case Study

A 60-year-old couple with $4 million in a securities portfolio, 3 million in retirement plans and $3 million in real estate. Both kids are professionals but are naïve in financial skills. Both spouses grew up with modest means and have enjoyed fine experiences of life. However they always felt void in the overall planning process. Before we did values based planning they had implemented wills, trusts (including an irrevocable life insurance trust, funded with a $4 million dollar second to die policy) and religiously contributed to their pension plan. They are great parents and instilled strong values in their kids. After the discovery interview with us and developing their mission statement and purpose statement we found out that following issues were important to them:

1. Develop a wealth transfer program that enables them to multiply their gift several fold to the next generation. Avail of all available exclusions.
2. Create a program whereby they can continue to help human causes and make direct impact on the beneficiaries.
3. Achieve inner peace and happiness by bringing family together.
4. Keep control until such time both kids become financially mature.
5. Retain the current lifestyle for lifetime.
6. Live the legacy and perpetuate the legacy.

Based on this, our virtual planning team (CPA, attorney and us) helped the clients by setting up a Survivorship ILIT with GSTT, a family foundation and used up $615,000 of their current assets to fund a $10 million last to die policy.

Over the last few years clients have given grants of over $500,000 to charities and have assets over $1 million in their foundation. We were able to create total wealth for each child at $15 million after 20 years as against $5 million. We were also able to create a program where upon their death their foundation will receive $5 million of their assets. They have involved their kids in shared philanthropy. The quarterly meeting has shifted their focus from performance review to their life planning progress tracking.

Here life insurance played a very important role in multiplying their gifts several times over. We see this as a unique opportunity because the majority of our clients have developed and implemented their wealth transfer plan on what's important to them. Their decision making is based on the desire to optimize their legacy.

Summary

Values-Based Planning

It will give us a sustainable market advantage.

It will protect and reinforce relationships.

It will give your firm increased effectiveness.

It increases client confidence.

It helps maximize a client's commitment and avoids buyer's remorse.

It reinforces your role as legal, financial and tax advisor.

By empowering clients to make wise decisions about their life planning issues we were able to develop and implement strategies that

a. Enhanced quality of our client's lives.
b. Created balance; to enjoy emotional values payoff and pursue other goals.
c. Gave clients an opportunity to do voluntary philanthropy, making a direct impact on the intended beneficiaries.
d. Allowed clients to decide wealth transfer when they want, to whom they want and the way they want.
e. Ensured orderly transition of their wealth and business interests.
f. Creating a family heritage bank that continues to perpetuate the client's legacy.
g. Effective utilization of life insurance program to multiply their gifts several fold
h. Allowed them to keep control and created a financial fortress.

Therefore helping people to live life with purpose and empower them with choices to make wise decisions can assure you great professional success and personal fulfillment.

The Irrevocable Life Insurance Trust

By Stephen J. Silverberg

With the winds of tax reform blowing, it is an appropriate time to revisit a popular and effective estate planning tool, the irrevocable life insurance trust (ILIT). The ILIT is a marriage of two favorite estate planning tools: life insurance and trusts. The use of an ILIT can prevent the "stacking of assets" as a result of the unlimited marital deduction. This occurs when assets are left outright to the surviving spouse only to be included in the taxable estate of the surviving spouse. As a result, life insurance proceeds can be effectively excluded from estate tax in both spouses' estates.

There are numerous advantages of using a properly drafted ILIT. These advantages include:

1. ILIT insurance proceeds will be out of the estates of both spouses for federal and state estate tax purposes if there are no incidents of ownership retained by grantor and the three-year rule is not violated.[1]
2. Avoidance of probate with its possible attendant delay, probate cost, administrative expense, public exposure, etc.
3. Income tax savings if the trust is funded. However, this is probably not as important of late as such a trust may now be in a higher income tax bracket than the grantor since trust income tax rates have been compacted.
4. It will help to solve the liquidity problem without adding value to the taxable estate of either spouse. This is usually the case in estates that may be "cash poor" or lacking in liquidity but rich in closely held business interests, real estate holdings, or other illiquid assets. The trustees can be given a permissive power (but not a mandate) to buy assets from either estate or lend money to either estate.
5. Avoidance of the problem of a new owner predeceasing the insured and the policy or policies coming back to the insured and being included in his taxable estate (unless other provisions are made for this contingency).

There are also some disadvantages of using ILITs. These disadvantages include:

1. The loss of freedom to directly control the policy or policies, e.g., marital breakup or access to cash surrender value.
2. You must use Crummey provisions to convert premium payments to gifts that qualify for the annual gift tax exclusion. This also raises the complex issue of the so called "hanging" power if the gifts exceed the greater of 5% of the trust corpus or $5,000.

In order to receive the benefit of estate tax exclusion the requirements of the Internal Revenue Code (IRC) must be met. There must be no incidents of ownership retained by the Grantor. These include the right to borrow, right to change beneficiaries, right to surrender or cancel, right to assign, right to revoke an assignment, right to pledge, a reversionary right exceeding 5% of the value of the policy. The retention of any of these rights will cause inclusion of the insurance proceeds in the gross estate.[2] It is important to note that payment of premiums has been held not to be an incident of ownership.

There must be a transfer of the policy and/or relinquishment of all incidents of ownership by the insured's estate under IRC § 2035. This section requires the insured to live three years after the transfer or relinquishment of the policy or the policy proceeds are includable in the estate. This three-year rule can be avoided by having the trust purchase the policy in the first instance. This way there is no "transfer" or "relinquishment" to trigger the three-year rule. The funds to pay the premium can be donated to the trust by the grantor of the trust.[3]

In the event of death within three years of transfer, the trust agreement could contain a "safety valve" to pay the proceeds outright to the surviving spouse or trigger Q-TIP treatment for the proceeds held by the trust. This would make the proceeds eligible for the marital deduction.

One should also be aware of the gift tax consequences of the establishment of an ILIT. In its "basic form" the assignment of a life insurance policy to a trust, or the payment of a premium by the grantor is a taxable gift of a future interest which is not eligible for the annual exclusion. The gift value of a policy

assigned is the cash replacement value plus prepaid unearned premiums (interpolated terminal reserve).

How can the gift tax issues be resolved? There are a number of strategies to address these issues. First, the Grantor can transfer policies having little or no value by borrowing out the cash value before transfer to the trust. With regard to premiums, the trustees may borrow against the cash surrender value to pay the premiums. Alternatively, properly drafted Crummey provisions in the trust document, converts the premium payments from gifts of a future interest to gifts of a present interest and thus eligible for the annual gift tax exclusion.[4]

No article on ILITs would be complete without a discussion of the Crummey powers. In *Crummey v. Commissioner*, *supra*, it was held that if a beneficiary had a non-cumulative right to withdraw a part of the donation to the trust, which right would lapse if not exercised fully during the year, the beneficiary had a present interest that qualified for the annual exclusion. The court also held the annual exclusion was available to minor beneficiaries as long as state law gives the guardians the right to exercise the right.

Since the decision in *Crummey*, the IRS has continually looked for ways to pierce what it perceives to be abuse in gifts to ILITs. The following are the basic rules governing Crummey powers:

1. The beneficiary must receive reasonable notice of the right to withdraw. Thirty days has been held to be reasonable.[5]
2. If the contribution is made late in a year, it still qualifies for the annual exclusion as long as the Crummey power is not keyed to the calendar year.[6]
3. If the beneficiary is a minor, the notice may be given to the parent. PLR 8008040 suggests that if the parent is a trustee, no notice is necessary; however, not to give the required notice is assuming a large unnecessary risk.
4. PLR 8143045 and 8121069 seem to permit a single notice if contributions are made on a regular basis, but TAM 9532001 stated that "current" notice is required. The conservative approach would be to give notice with each transfer to the trust.

Since the beneficiary will not normally exercise the Crummey power, it should be limited to $5,000 or 5% of the value of the trust to avoid gift tax consequences to the beneficiary. However, if the premium is large, this may limit the amount of premiums that the grantor may pay without utilizing his or her unified credit or paying gift tax. One tact taken is appointing additional beneficiaries to get more exclusions. These beneficiaries are usually contingent which gives rise to the IRS's scrutiny. The IRS has attacked this in PLR 8727003 and 9045002. The tax court in *Cristofani v. Commissioner*[7] rejected the IRS argument and allowed annual exclusions for grandchildren who had remote contingent interests in the Trust. However in Actions on Decision, AOD 1992-10, and AOD 1996-10, and TAM 96208004, the Internal Revenue Service has indicated that it will scrutinize the facts and circumstances of each case to determine whether the right of withdrawal is "illusory."

In *Kohlstadt v. Commissioner*, T.C. Memo 1997-212, the Internal Revenue Service again attacked the validity of giving Crummey powers to remote beneficiaries. Again the court held that as long as a beneficiary has a present interest in the trust, the grant of these powers to them was valid. Subsequent to *Kohlstadt* the IRS issued TAM 9731004 which again disallowed the granting of Crummey powers to remote beneficiaries and contended that if there was a prearranged plan that the powers would not be exercised, the powers were invalid.

Another important point to note is the grantor can retain the right to limit the amount of donations subject to the right of withdrawal and designate those beneficiaries of the trust who have a right to withdraw in a particular year.[8] In the elder law context, by retaining the right to designate Crummey power holders, one can avoid disqualifying a beneficiary who is receiving means tested benefits.

The so called "hanging powers" can allow a beneficiary to exceed the $5,000/5% limitation. Hanging powers are still viable but IRS looks at them with a jaundiced eye. Care should be taken to use language that will qualify. The hanging power is illustrated by the following example:

> The grantor creates an irrevocable life insurance trust with a policy that requires an annual premium payment of $10,000 a year for seven years. There is only one beneficiary who has the right within thirty days of notification to withdraw the entire amount each year. Under the terms of the trust agreement the right laps-

es only to the extent of the greater of $5,000 or 5% of the assets in any year. When the first premium is paid, the beneficiary has a right to withdraw $10,000. After the 30 day period, the right of withdrawal lapses only the extent of $5,000. The beneficiary's right to withdraw the remaining $5,000 lapses on January 1 of the following year and, as a result, the right of withdrawal triggered by the second premium payment will not lapse during the second year because of the limitation on the amount of lapse in any given year. After seven years, the beneficiary will have the right to withdraw $35,000, since an additional $5,000 a year will become subject of the beneficiary's right of withdrawal. In the eighth year, if no premium payment is made, the $35,000 amount will be reduced to $30,000. At the end of 14 years, the beneficiary will no longer have a right to withdraw assuming no additional donations are made. If the cash surrender value of the life insurance policy exceeds $100,000 before the end of the 14 years, the right of withdrawal will lapse sooner since the 5% amount will be greater than the $5,000 amount. If the beneficiary dies before the right of withdrawal completely lapses, the amount that has not lapsed will be included in the beneficiary's gross estate.

The use of ILITs will undoubtedly continue in the upcoming years. Even with the repeal of estate tax, it will remain an important planning tool. The asset protection features are by themselves enough reason to utilize an ILIT. With the proceeds of an insurance policy in an ILIT, the beneficiary has extremely strong protection from claims of creditors, tax claims and marital issues. By including supplemental needs language in an ILIT, provision for the care a disabled child can be easily accomplished. In short, most practitioners will rely more on this valuable planning tool in the years to come.

Endnotes

1. See the *Leder, Headrick* and *Perry* cases; *infra*, for a discussion of how to avoid exposure to the three-year rule.
2. Reg. 20.2042-1(c)(2); IRC § 2042(2).
3. *Estate of Leder*, 893 F.2d 237 (10th Cir. 1989); *Estate of Eddie L. Headrick*, 918 F.2d 1263 (6th Cir. 1990); *Estate of Frank N. Perry, Sr.*, 91-1 USTC Par. 60064 (5th Cir. 1991).
4. *Crummey v. Comm.*, 397 F.2d 82 (9th Cir. 1968).
5. *See* PLRs 8712014, 8813019, and 8922062.
6. *See* Rev. Rul. 83-108, 1983-2 C.B. 167; PLR 8806063.
7. 97TC74 (1991).
8. PLRs 8051128, 8103069, 8103074; TAM 8901004.

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Are You Buying Life Insurance or an Illusion?

By Fredric J. Laffie

Yesterday's insurance products were quite easy to understand. You had a choice of whole life or term life. Today, we have annual renewal term, guaranteed level term, universal life, variable universal life, variable whole life, blended whole life and term, second-to-die (universal, variable, whole life, and blends), and first-to-die written on a minimum of two lives. In addition, there are hybrids of the above mentioned products.

Can the consumer possibly understand what they are buying? Unfortunately, more often than not, they are buying illusions. Variable life "illustrated" at a 12% return or, even worse, on an historical basis or universal life illustrated with assumptions that interest rates will increase in years 11 through 15, 16 through 21, and thereafter are just examples of what is being presented by insurance agents. With the age of computers, the agent can qualify as an illusionist, somewhat like Siegfried and Roy. Illusionists make tigers disappear. Many products being sold today also will disappear when you most need them!

One major life insurer has decided that unless a policy illustration "holds up" after reducing dividends by 1½% they will not permit the agent to make the sale. Unfortunately, when presented in a competitive bidding war, the legitimate insurance professional is at a disadvantage. *Unless professionals such as CPAs and attorneys take a more active role with the clients, more often than not, the proposed insured will probably be duped or not truly understand the potential pitfalls of the products purchased.*

Are all agents trying to fool the public? I believe the answer is no. I also believe, however, that many agents are selling products that they don't thoroughly understand. Is that as bad as duping a client? I'm not sure, but the outcome could be similar!

How may clients buy insurance as an "investment"? Great deal? Wrong! How many individuals buy insurance and are told, "You only pay ten premiums and the policy is paid in full." Wrong! Some policies that have been sold this way will never vanish. There are some class action suits against some major insurance carriers due to these misleading sales practices.

The September 18, 1995 issue of the *National Underwriter* correctly points out that some policies purchased in the late 80s had projected to pay premiums for ten years "give or take a few years." The premiums will end up being paid for as much as 30 years. This is due to significant declining investment returns translating to reduced dividends.

Unfortunately, the above scenario becomes magnified when whole life contracts are aggressively blended with term insurance. These products are like "mixing prescription drugs with alcohol." Keep in mind, the more non-guaranteed term we mix with whole-life contracts, the more sensitive these products become to dividend reductions.

"Unless professionals such as CPAs and attorneys take a more active role with the clients, more often than not, the proposed insured will probably be duped or not truly understand the potential pitfalls of the products purchased."

The reason people buy whole life is for the guarantees. If we are too aggressive with the term blend, we might as well buy universal life, which also lacks many guarantees but could be more flexible and have better loan provisions.

Recently, I was asked to review an existing policy that was sold when dividends were quite high. The insureds are now over 70 years of age and the surrendering of paid-up additions to pay for the term insurance portion of this policy is inadequate. The insureds knew this could happen but were told that they could increase the premium at any time. In New York State, this particular product does not allow for additional monies to be added, thus the insurance coverage will have to be reduced. These individuals had thought they purchased $10 million of second-to-die insurance. At the end of the year, however, the

coverage will drop to about $8 million and further drops could follow.

Illusions, illusions, illusions. No products are perfect. But the keys to choosing the right insurance policies are 1) a conservative approach; and 2) a knowledgeable insurance professional who can help you review and understand the importance of insurance carriers' ratings, dividend history, mortality margins (death claim experience), and whether or not mortality charges are guaranteed even with a reduced dividend scale.

As a former practicing CPA and now an insurance specialist, I have seen both sides of the coin. *Caveat emptor!*

Fredric J. Laffie, CPA, CSP, operates his own insurance firm in Syosset, New York (516) 364-9797 ext. 317. He is an Insurance Specialist with a major concentration on Estate Planning and closely held business clients. Business Experience: Oppenheim, Appel, Dixon & Company; Arthur Andersen & Company; Vice President, Major Life Insurance Carrier; Sole Practitioner. Professional Associations and Honors: Certified Public Accountant; Certified Systems Professional; Member and former Chairmen of the New York State Society of CPAs Estate Planning Committee, Nassau Chapter; On the faculty of a major charitable organization; Million Dollar Round Table—"Top of the Table." Articles and Lectures: Written and lectured on life insurance relating to Estate Planning at Fordham Law School (graduates); Lectures at the New York State Society of CPAs Estate Planning meetings; Lectures at the New York State Society of CPAs Personal Financial Planning meetings; Lectures to numerous law and accounting firms; Lectures at the New York State CPA Accounting Conferences; Lectures at the Long Island Estate, Tax and Financial Planning Conferences; Lectured for St. John's University Continuing Education program for CPAs; Quoted in newspapers and magazines; Articles published in the *CPA Journal*.

ELDER LAW NEWS

REGULAR COLUMNS

Case News

By Judith B. Raskin

Medicaid Recovery

DSS appealed from a decision denying recovery from the infant plaintiff's personal injury settlement proceeds that were not allocated to medical expenses. Reversed. *Santiago v. Craigbrand Realty Corp.*, __A.D.2d__, __N.Y.S.2d__ (1st Dep't 2000).

The infant plaintiff settled his personal injury action for $140,000. No portion of the settlement was allocated to medical expenses. DSS sought to enforce its lien of $12,857.06 for past medical expenses. The Supreme Court held that DSS could only recover from those proceeds allocated to medical expenses. DSS appealed.

The Appellate Division reversed. The opinion traces the relevant statutory and case history of this issue. In summary, SSL § 104(1) provides that DSS can recover from a person who had care provided within the last ten years. Section 104(2) prohibits DSS from recovering from an infant under the age of 21 unless the infant had sufficient funds at the time the care was provided. In response to the difficulties encountered in collecting from personal injury settlements, SSL § 104(b) was enacted which provides that the public welfare official shall have a lien against the proceeds of a personal injury action granted to a recipient of public assistance. 104(b) did not address whether the lien was effective against an infant. However, in *Baker v. Sterling*, DSS was unsuccessful in arguing that under § 104(b) it could collect against the personal injury settlement proceeds of an infant. The court held that § 104(b) was procedural and that § 104(2) set forth the right of recoupment. In *Baker*, DSS could only recover from that portion of the settlement proceeds attributable to medical expenses.

SSL §§ 366(4)(h)(1) and 367-(a)(2)(b) were then enacted. Section 366(4)(h)(1) requires a Medicaid recipient to assign to DSS his right to reimbursement from a third party. Section 367-(a)(2)(b) provides that DSS can recover from the recipient's right to medical support or third party reimbursement. In *Cricchio v. Pennisi*, DSS successfully relied upon these sections in arguing that its lien must be satisfied from settlement proceeds before the proceeds could fund a supplemental needs trust. The court stated that the right of recovery was based upon §§ 366 (4)(h)(1) and 367-(a)(2)(b) and not § 104. These sections were also relied upon in C*alvanese v. Calvanese* where the court held that all of the settlement proceeds of an adult recipient were available to satisfy the lien.

The Appellate Division found that because the right of recovery in this case is based upon §§ 366(4)(h)(1) and 367-(a)(2)(b), § 104(b) does not apply. All of the proceeds are available to satisfy the lien. The court stated that this holding follows federal mandates that the Medicaid program should be the payor of last resort.

Plaintiff DSS appealed from a decision granting defendant's motion to dismiss the complaint seeking recovery from a refusing spouse of a Medicaid recipient. Reversed. *Commissioner of DSS v. Fishman*, __A.D.2d__, __N.Y.S.2d__ (1st Dep't 2000).

At the time Mr. Fishman's application for institutional Medicaid was granted, Mrs. Fishman had excess resources of $421,807.59 and excess income of $537.48. Mrs. Fishman signed a declaration that she would not make her income or resources available for her husband's care. During the time medical assistance was provided, DSS sent Mrs. Fishman three letters demanding contribution. Mrs. Fishman failed to respond. Shortly after Mr. Fishman died, DSS started an action to recover its costs from Mrs. Fishman. The complaint was dismissed. Her successful argument was based upon two cases, *Estate of Craig* and *Steuben County v. DSS v. Deats*. In these cases, the estates of the surviving spouses of recipients of public benefits were deemed unavailable for recovery because the spouse did not have sufficient ability to pay while the care was provided. Mrs. Fishman argued that DSS only had a snapshot of her assets and income at the time of application and did not allege in its complaint that she had excess resources at any time during the period that her husband was receiving care. DSS appealed.

The Appellate Division reversed, holding that the allegations in the complaint were sufficient to plead a cause of action. DSS had an implied contract with Mrs. Fishman, created at the time she refused to make her resources available. The court noted that Mrs. Fishman never advised DSS that she no longer had excess income or resources and that DSS cannot be required to continually assess the resources of refusing spouses.

Medicaid/Social Security

Plaintiff nursing home sought a directive requiring the resident Medicaid recipient to pay his income contribution from his Social Security payments (denied) and a judgment against the defendant for his arrears (to be granted upon evidence of costs). *Park Hope Nursing Home, Inc. v. Eckelberger*, __Misc. 2d __, __N.Y.S.2d__ (Sup. Ct., Monroe Co. 2000).

The defendant nursing home resident received medical assistance. His Social Security benefits were his only source of income and resulted in an income contribution of $710. Although the defendant had signed a contract with the nursing home agreeing to pay the income contribution, defendant had never done so. The nursing home brought this action to require specific performance and payments from defendant's Social Security income and for a judgment of $23,883.46 and for costs, disbursements and attorneys fees. The defendant failed to appear but an attorney from the Volunteer Legal Services Project represented him and argued that the complaint failed to state a cause of action because Social Security income is exempt under 42 U.S.C. § 407(a).

The court denied the nursing home's request for specific performance but agreed to issue a default judgment once evidence was presented to establish the proper sum. 42 U.S.C. § 407(a) precludes state and local governments from attaching Social Security benefits. Most cases involving this statute are brought for the purpose of invalidating a legislative act allowing attachment of these funds This case involves a private contract. The court denied specific performance because the defendant never specifically agreed that he would pay his Social Security to the nursing home and by his papers, the defendant opposes giving any future Social Security payments to the plaintiff.

Medicaid

DSS appealed from a determination that where Medicaid was paying for hospitalization, the calculation of the income spenddown for the recipient must allow for the support of his ineligible spouse. *Marzec v. DeBuono*, __ N.Y.2d __, __N.Y.S.2d__, __N.E.2d__ (Ct. of Appeals, 2000).

The defendant applied for Medicaid in 1996. His income, $717 in Social Security benefits, put him over the income allowance by $138 per month. Shortly thereafter, he was hospitalized for a week. Erie County DSS determined that he must spend down all of his $138 per month excess income for six months. This would leave him with a medical bill of $711. DSS did not allow defendant an allowance for the support of his wife. Defendant appealed, arguing that he should receive an allowance for spousal support. The DSS position was upheld at a fair hearing and an article 78 proceeding but reversed at the Appellate Division.

The Court of Appeals reversed. There are no federal guidelines authorizing an allowance for the support of a spouse who is not over 65, blind or disabled. Therefore, DSS did not act unreasonably in making its determination.

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 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 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.

Fair Hearing News

By Ellice Fatoullah and René H. 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 Reixach, Esq., at Woods, Oviatt, Gilman, Sturman & Clarke 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.

Copies of the Fair Hearing decisions analyzed above may be obtained by visiting the Web site of the Western New York Law Center, wnylc.com/Fair Hearing Database. The "keyword" for all of the decisions cited is "Trusts and Medicaid eligibility."

In re the Appeal of L. S.

Ellice Fatoullah

Holding

The Agency's determination to deny Appellant's Medicaid application on the ground that Appellant possessed excess resources contained in a trust fund established by agreement in 1986 which contained a "trigger clause" was incorrect. New York State's trigger trust law enacted in 1992 may be applied prospectively only.

Facts

Appellant established an irrevocable trust on July 28, 1986. As of July 3, 2000, the value of the trust corpus was approximately $153,700. The trust beneficiaries were the Appellant's daughter and grandchildren.

The trust instrument, ¶ 1.A, provides as follows:

> The Trustee is authorized to pay to or for the benefit of the Grantor from time to time so much of the income and principal of this trust as the Trustee deems sufficient in her absolute discretion to provide for Grantor's comfort, support and maintenance, except that no payment of income or principal in any respect shall be allowed, authorized or made for the benefit of the Grantor if the Grantor is receiving financial assistance from New York State or any other governmental unit or agency, or would qualify for such assistance if the right to receive payment from this trust terminated, and payment of income and/or principal from this trust would either disqualify her from receiving such assistance, or would be subject to payment over to such governmental unit or agency in whole or in part as reimbursement for assistance paid to said Grantor.

René Reixach

By notice dated July 3, 2000, the Agency determined that for the purposes of determining eligibility for medical assistance ("Medicaid"), the entire value of the trust corpus, $153,700, would be included as available to the Applicant because of the above provision, and denied Appellant's application for assistance. On August 25, 2000, Appellant appealed and filed for this fair hearing.

Applicable Law

The Consolidated Budget Reconciliation Act of 1985 (COBRA 1985), amended the federal Medicaid laws, 42 U.S.C. §§ 1396a *et. seq.,* to provide for the counting of assets held in a "Medicaid qualifying trust" (MQT) as available in determining the Medicaid eligibility of certain trust beneficiaries. A Medicaid qualifying trust is a trust, or similar legal device, established by an individual or by his or her spouse, other than by a will, under which the individual may, in a Trustee's discretion be able to receive income and or principal from the trust. In such a circumstance, the entire amount of the income and/or principal that may be made available to the individual must be counted in determining the individual's eligibility for Medicaid, regardless of whether the Trustee chooses to exercise his or her discretion in favor of the beneficiary. This COBRA provision, formerly 42 U.S.C. § 1396a(k), was deleted in August of 1993 and essentially re-codified at 42 U.S.C. § 1396(p)(d). The State Administrative Directive implementing COBRA, 88

ADM-32, provides that it applies to trusts already in existence.

In 1992 New York drafted provisions to respond to the perception that estate planners and attorneys were drafting trust agreements which would terminate upon application for Medicaid as a means of circumventing COBRA's restrictions.[1] Specifically, EPTL 7-3.1(c) states that any provision in a trust, other than a testamentary trust, which provides directly or indirectly for the suspension, termination, or diversion of the principal, income or beneficial interest of the creator or the creator's spouse, should either apply for Medicaid or require medical care, will be void, without regard to the irrevocability of the trust or the purpose for which the trust was created. This statute, known to practitioners as the "trigger trust" law, states that it applies only to trusts created on or after April 2, 1992.

Social Services Law § 369.3 authorizes a Social Services district to recover the amount of Medicaid paid on behalf of a creator or a creator's spouse from his or her beneficial interest in a trust, in the event that Medicaid is furnished to, or on behalf of, the creator or the creator's spouse.

New York State regulation, 18 N.Y.C.R.R. § 360-4.4(a), defines an applicant or recipient's available resources as including certain resources of a Medicaid qualifying trust as explained at 18 N.YC.R.R. § 360- 4.5.

New York State regulation 18 N.Y.C.R.R. § 360-4.5(a) reiterates the law on Medicaid qualifying trusts stated above, and applies it to inter vivos trust created before August 11, 1993. 18 N.Y.C.R.R. § 360-4.5(d) reiterates the above stated provision on trigger trusts, and applies that law to trusts created on or after April 2, 1992. Administrative Directive, 92 ADM-45 further implements the 1992 provisions, and repeats that the law is effective only for trusts created on or after April 2, 1992.

Discussion

The record established that the Agency determined to deny the Appellant's application for medical assistance on the ground that Appellant had available resources in excess of the applicable resource exemption, namely the principal of the trust in question.

Pursuant to Administrative Directive 88 ADM-32, the state policy implementing the federal Medicaid qualifying trust provisions, the maximum amount of payment that may be permitted to be distributed under the terms of a Medicaid qualifying trust, assuming the full exercise of discretion, must be included in the income and resources considered available to the Appellant for purposes of eligibility for Medicaid, regardless of when the trust was created.

The uncontroverted evidence established that the trust created by Appellant was an irrevocable trust; and that the language contained a "trigger clause." Specifically, the trust provided that the Trustee may invade the trust principal to or for the benefit of the Appellant, unless the Appellant is receiving state financial assistance or would qualify for such assistance, at which point payments from the trust must terminate.

The Agency argued that pursuant to federal law, the trust in question is a Medicaid qualifying trust because the Trustee is permitted to exercise discretion over the entire trust corpus to pay income and/or principal to or for the benefit of the Grantor, and the federal MQT law requires that the full amount of the corpus must be considered as available to the Grantor/Applicant in instances where a Trustee possesses such discretion. The Agency also recognized that the trust contained a classic "trigger clause." However, since the federal MQT law is effective to trusts established in 1986, the Agency's argued that the trigger trust clause in this trust should not prevent the Agency from disqualifying the Appellant from possessing excess resources contained in an MQT.

Citing the cases of *Masterson v. Department of Social Services*,[2] *Trust Co. v. State*,[3] *In re Epping*,[4] and *In re Kellogg*,[5] Appellant argued that the Medicaid qualifying trust rule not withstanding, a trust must be construed in accordance with the intent of its creator as evidenced by the terms of the trust, and under the terms of this trust, i.e., because of the trigger provision, no resources are available to the individual. Stated another way, Appellant argued that the "trigger clause" is effective because EPTL 7-3.1(c) may not be applied retroactively (by its terms, the law applies only to trusts created after April 2, 1992)[6]; and if the trigger clause may not be voided, then the Trustee does not have any discretion to pay either income or principal to or for the benefit of the Grantor, and the trust is not an MQT.

Finally, Appellant argued that the State Administrative Procedure Act, § 203 and *Rudin Management Co., Inc. v. Commissioner*,[7] provide that a state agency must lawfully promulgate regulations before it may change policy which affects the public; and, absent a clear legislative indication to the contrary, administrative regulations must be prospective only, and if retroactive, may not impair vested rights or create new rights. Since there was no such clear authority to

the contrary,[8] the regulation implementing the trigger trust law must be implemented prospectively only.

The fair hearing decision found for Appellant in light of the express language of the trigger trust statute and its implementing ADM requiring that the trigger trust law be applied prospectively. The decision also cited *Bourgeois v. Stadler,*[9] for the same proposition, although the case rested primarily on other grounds.

Fair Hearing Decision

The Agency's decision to deny Appellant's Medicaid application on the ground of excess resources contained in the trust described above was reversed and the matter was remanded to the local Agency to redetermine Appellant's Medicaid eligibility consistent with the decision.

The Appellant at this Fair Hearing was represented by René H. Reixach, Esq., of Rochester, New York.

In re the Appeal of S. T.

Holding

Trust assets will not be deemed "available" to the Grantor in computing the Grantor's eligibility for Medicaid, where the trust was established ten years before applying for Medicaid, and the trust agreement contained a spray provision giving the Grantor the power to consent to distributions of the corpus of the trust, so long as the consent power is not exercised.

A trust agreement containing limited lifetime and testamentary powers of appointment will not render the trust fund assets "available" to the Grantor.

But where the trust contained a spray provision giving the Trustees the power to spray the corpus of the trust to the Grantor's descendants, except that no more than $10,000 of the corpus could be paid to one of the Trustees of the trust without the Grantor's consent, and well in excess of $10,000 was paid to such Trustee, the facts supported a finding that the Grantor consented to the trust distribution. Under such circumstances, the transfer was deemed a transfer made by the Grantor, and the amount of the transfer included in determining the appropriate transfer of assets penalty period.

Facts

On or about October 1, 1999, Appellant, age 91, entered a nursing home located in Syracuse, New York. On October 14, 1999, Appellant applied for nursing home Medicaid.

On November 26, 1990, Appellant as Grantor, and J.T., M.D. and F. T., as Trustees, entered into an irrevocable trust agreement. The trust agreement provided that income would be paid to the Grantor for her life. The trust agreement, at ¶ 4(B), also provided that

> The Trustees may, in the exercise of absolute discretion, distribute any part of the principal of this trust, including the entire amount thereof, to or among the Grantor's descendants, (or may apply such amounts for their benefit) in such shares and proportions as the Trustees shall determine to be desirable. Notwithstanding the previous sentence, J.T. shall be limited to principal distributions of no more than $10,000 in any single calendar year. The Grantor shall also have the power, exercisable at any time during the Grantor's life, to appoint any part or all of the principal of this trust to or for the benefit of any descendants of the Grantor. Such power shall be exercised only by an acknowledged writing of the Grantor, or by the Grantor's Will, and either of such document shall make specific preference (sic) to this paragraph. Such appointment may be outright or in trust, and need not be equal.

By notice dated August 24, 2000, the Agency informed Appellant of its determination to deny Appellant's medical assistance application because, *inter alia*: (i) Appellant's household had resources in excess of the allowable Medicaid resource standard by $179,957.62; (ii) Appellant's income exceeded the applicable income allowance; and (iii) assets valued at $172,770.01 were transferred by the Appellant for less than fair market value.

The fair hearing decision did not list all the transfers made by the Applicant, but the decision reported that over 50 transfers were made from the period from October 1997 through September 1999, and that the transfers were made from the trust as well as from two bank accounts held jointly by the Appellant and her son, J.T. The sum of the uncompensated transfers when aggregated, for which no penalty period had lapsed, was found to be $172,770.01; and the penalty period was computed by dividing $172,770.01 by $4,944, the then applicable regional transfer of assets rate, to arrive at a penalty period of 34.94 months, commencing the first day following

the month of the transfer, or from November 1, 1997. The penalty period terminated on August 31, 2000, with a fractional amount to be applied against the September "NAMI," or Net Available Monthly Income.

Appellant's income from Social Security and pensions totaled $2,622.03, for the period from October 1, 1999 through December 31, 1999. For the year 2000, the total income was $2,697.81. The Agency then deducted the $20 unearned income disregard and $135.37 for monthly health insurance premiums to arrive at Appellant's total monthly net income. From these sums, the applicable Medicaid income standard for a family of one, namely $592 for 1999, and $600 for 2000 was deducted, leaving a NAMI of $1,874.66 for 1999, and $1,942.44 for 2000.

The Agency calculated Appellant's excess resources by considering the remaining assets of the trust, which were $183,507.62, and deducting from that sum the then in existence Medicaid resource allowance for a family of one of $3,550, leaving net excess resources of $179,957.62.

Applicable Law

An applicant will be eligible for Medicaid benefits if the applicant meets certain income and resource eligibility requirements. To determine eligibility, an applicant's or recipient's net income must be calculated. In addition, resources are compared to the applicable resource level. Net income is derived from gross income by deducting exempt income and allowable deductions. The result—net income—is compared to the statutory "standard of need" set forth in S.S.L. § 366.2(a)(7) and 18 N.Y.C.R.R. § 360-4. If an applicant or recipient's net income is less than or equal to the applicable monthly standard of need, and resources are less than or equal to the applicable resource standard, full medical assistance coverage is available.

The amount by which net income exceeds the standard of need is considered "excess income." If the applicant or recipient has any excess income, the applicant must incur medical bills equal to or greater than the excess to become eligible for medical assistance. If a person has expenses for in-patient hospital care, the excess income for a period of six months must be considered available for payment. For other medical care and services, the excess income for the month or months in which care or services are given must be considered available for payment of such care and services. But the regulations provide that this excess income may be offset against incurred medical expenses so that an individual can become eligible for medical assistance. This offsetting process is called "the spend down," and is explained more fully at 87 ADM-4.

18 N.Y.C.R.R. § 360-4.6 provides for certain income disregards in the following order: (1) dependent family member income allowances; (2) the first $20 per month of unearned income; (3) health insurance premiums; and (4) interest earned on excluded burial funds appreciation in the value of an excluded burial arrangement which are to become part of the separately identifiable burial fund.

In addition, S.S.L. § 366(2)(b)(3) now provides for a "pay-in" program by which an individual with excess income may simply remit the amount of the excess to the local district each month, and receive uninterrupted authorization for full coverage for all costs (at the Medicaid rate) of all necessary medical services by participating providers.

As to resources, if the applicant or recipient's resources exceed the resource standards, the applicant or recipient will be ineligible for medical assistance until he/she incurs medical expenses equal to or greater than the excess resource standards. 18 N.Y.C.R.R. § 360-4.1. The applicant or recipient will be given ten days from the date he or she is advised of the excess resource amount by either establishing a burial fund not to exceed $1,500 or by spending such excess on exempt burial space items during this ten-day period.

Where an applicant/recipient has excess resources, Administrative Directive 91 ADM-17 requires local districts to advise the applicant or recipient of the Medicaid resource spend down rule. Eligibility determinations must include a snapshot comparison of excess resources as of the first of the month and compare the excess to outstanding medical bills. This comparison must be done for each month in which eligibility is sought, including each of the retroactive months for which assistance is sought. The client is not eligible for assistance until the amount of viable bills is equal to or greater than the amount of excess resources remaining after offsetting the purchase of burial-related items, and viable medical bills, in that order. The Directive further provides that whenever a notice is sent to an applicant accepting the application with a spend down requirement, or denying an application because of excess resources, the Agency is required to include notice of procedures explaining how to spend down excess resources.

An applicant's/recipient's available resources, as defined in 18 N.Y.C.R.R. § 360-4.4(a) includes:

> (1) all resources in the control of the applicant/recipient. It also includes any resources in the control of anyone acting on the applicant's/recipient's behalf such as a guardian, con-

servator, representative, or committee;

(2) certain resources transferred for less than fair market value as explained in 360-4.4;

(3) all or part of the equity value of certain income-producing property, as explained in 360-4.4(d);

(4) certain resources of a legally responsible relative, as explained in 360-4.3(f); and

(5) certain resources of a MA-qualifying trust, as explained in 360-4.5.

Sections 360-4.1 and 4.8(b) of 18 N.Y.C.R.R. provides that all income and resources actually or potentially available to a Medicaid applicant or recipient must be evaluated, but only such income and/or resources as are found to be available may be considered in determining eligibility for Medicaid. A Medicaid applicant/recipient (a/r) whose 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.

Under Administrative Directive 96 ADM-8, at § IV.I, rules for determining the treatment of jointly held assets provide that the general rule is that joint property held by an applicant/recipient is considered available to the extent of the a/r's interest in the property. In the absence of documentation to the contrary, it is presumed that all joint owners possess equal shares. However there are special rules for SSI-related (aged, blind or disabled) a/r's availability of assets contained in financial institutional accounts. In the SSI-related situation, assets held jointly will be presumed to belong entirely to the applicant/recipient, but this presumption may be rebutted if the a/r: (1) submits a written statement along with the other account holders, explaining why there is a joint account, who made the deposits and withdrawals, and how the withdrawals have been spent; and (2) separate the funds owned by the SSI-related a/r.

S.S.L. § 366.5(d) and 18 N.Y.C.R.R. § 360-4.4(c)(2) set forth the rules governing impermissible transfers of assets. Generally, in determining the Medicaid eligibility of a person receiving nursing home benefits, including hospital services provided on "alternate level of care" days, as well as Lombardi or waivered home care services, any transfer of assets for less than fair market value made by the person, or his or her spouse, within or after the "look-back period" will render the person ineligible for nursing home Medicaid for a period of time, depending on the amount transferred. The "look-back period" is the 36-month period immediately preceding the date that a person receiving nursing facility services is both institutionalized and has applied for Medicaid. However, in the case of payment to or from a trust which may be deemed assets transferred by an applicant or recipient, the "look-back period" is a 60-month period instead of the 36-month period. A non-exempt transfer of assets for less than fair market value will cause the applicant or recipient to be ineligible for nursing facility services for a period of months equal to the total cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average cost of care to a private patient for nursing facility services in the region in which such person seeks or receives nursing facility services, as of the date the person first applies as an institutionalized person. The period of ineligibility begins with the first day following the month of the transfer.

Discussion

This fair hearing decision is about as clear as mud. The decision affirmed the Agency's finding that Appellant made $172,000 worth of aggregated impermissible transfers, and computed a disqualification period of 34.94 months, commencing as of October 1, 1997 and expiring on August 31, 2000, with a fractional spend down for the month of September, 2000. However, both the "Fact Finding" section and the "Discussion" section of the decision listed a series of transfers, neither of which add up to $172,000. To make matters worse, no part of the decision lists the transfers made in 1997; and the "Discussion" section of the decision reports that $245,000 worth of transfers were made from the trust alone, but according to counsel for the Appellant, there was no dispute that approximately $150,000 of those transfers were loans by the Trustee, and not considered transfers by the Agency. Finally, a series of uncontested—and partially unreported—transfers were made from two joint accounts held in the name of the applicant and J.T., her son.

The Agency representative contended that when J.T., as Trustee, withdrew and paid to himself in excess of the $10,000 permitted to him under the trust terms, his actions "invalidated' and "voided" the trust, and therefore, the remaining assets in the trust were "available" to the Grantor.

The Appellant's attorney testified that the trust in question was an irrevocable trust and in existence for almost ten years. He maintained that the trust was funded at its creation and therefore almost ten years had passed since a transfer had occurred. He stated that under the terms of the trust, the Appellant was entitled to receive only the income of the trust and

was given only limited powers of appointment—not the right to receive the money during Appellant's lifetime. The Appellant's attorney noted that the Appellant had authority to allow J.T. to distribute more than $10,000 in trust principal each year. He contended that there was no evidence that the distributions to J.T. were unauthorized by the Appellant. He also made the argument that the Appellant retained income rights to the trust principal only so that withdrawals form the principal should not be considered transfers by the Appellant. He also noted that under the terms of the trust, the Appellant could not have received payment of trust principal. Finally, he stated that the purpose of the limited power of appointments was for tax purposes.

On the question of the availability of the trust fund assets, the decision found for Appellant, finding that there was no provision in the trust instrument that would allow Appellant to have access to the principal of the trust. Also, there was no legal support for the contention that the actions of J.T. "invalidated" or "voided" the trust agreement. Therefore, that part of the Agency's determination was reversed. The decision also found that the Agency had no basis for denying the application for excess income without notification to the Applicant of the spend down process.

However, the decision upheld the Agency's determination to deny Appellant's application for 34.94 months through August 31, 2000 based upon aggregated uncompensated transfers of resources. The decision found that under ¶ 4(B) of the trust, J.T. was limited to principal distributions of no more than $10,000 in any single calendar year. As the Appellant's attorney noted, Appellant had the power to authorize additional distributions of trust principal beyond the $10,000 limit; and because there was no evidence that any of J.T.'s distributions to himself were unauthorized, the fair hearing decision took this non-evidence to mean that the trust payments made in excess of $10,000 to J.T. were authorized by the Grantor. And if they were authorized by the Grantor, the decision reasoned that the Grantor is an individual who took direct action to transfer assets. The amount of the transfers, therefore, were calculated in computing Appellant/Grantor's appropriate transfer of penalty period.

The decision also found that the Agency's determination to deny the application for excess income, without advising Appellant of the mechanism for "spending down" such excess, was incorrect.

Fair Hearing Decision

The Agency's determination to deny the Appellant's application for medical assistance on the grounds that the Appellant's household has net income and resources in excess of the medical assistance standards was not correct and was reversed.

The Agency's determination that the Appellant is not eligible for nursing facility services for a period of 34.94 months is correct.

The decision, dated October 4, 2000, directed the Agency to provide medical assistance benefits for nursing home care to Appellant upon expiration of the penalty period (August 31, 2000) subject to the Appellant's NAMI.

Editor's Comment

This decision is instructive in many ways. First, the facts clearly recite that the trust agreement contained limited lifetime and testamentary powers of appointment. Yet the Agency below did not raise, and the fair hearing decision did not comment upon, the question of whether the retention of those limited powers would be a basis for denying the case on the ground that such powers made the trust assets "available" to a Grantor. In other words, the decision lets stand a trust with lifetime and testamentary powers of appointment. We believe this decision, dated October 2000, is legally correct, and follows the recent fair hearing decision of *In re Antionetta G.,* (November 9, 1999). Presumably, these two fair hearing decisions supercede previously reported fair hearing decisions, which were discussed in prior columns which held otherwise.[10]

Since *In re Antoinetta G.,* was decided in 1999, there has been a fairly even split between elder law practitioners who continue to write trust agreements with powers of appointment (mainly practitioners coming to the practice from the tax side), and practitioners who chose to leave the provisions out (mainly coming to elder law from the government benefits side.) As of this fair hearing decision, obviously, the argument for inclusion is stronger. However, the argument for excluding lifetime and testamentary powers of appointment still exists. Given the different standards of review by local Agencies (New York City still requires the offending powers be deleted as a condition of Medicaid eligibility), and the fact that neither the instant decision or *In re Antoinetta G.* fully address the issue, there is still a risk of having your case go to a fair hearing, or beyond; and given New York State's gift tax law's amendment, and the rising federal gift tax exemption, they may be little need to take the risk. However, in instances where there is a good reason for including a power of appointment, such as the need to have unappreciated property included in the Grantor's estate for step up in basis purposes, the cost/benefit analysis shifts.

A provision giving the Grantor the retained power to consent to the distribution of trust corpus to someone other than the Grantor (usually set forth in a "spray" provision) may be drafted purely for control purposes, or for tax as well as control purposes, depending on whether the sprayee is also the Trustee. Concerning this issue, by finding that a clause giving the Grantor the power to consent to the transfer of trust fund assets will not render the trust fund assets "available," but then finding that the exercise of the Grantor's discretion under the same clause would be deemed a transfer of assets—the decision is illogical and makes no sense.

As the instant decision points out, however, when such a clause is drafted, and the Grantor's consent is given, and sizable sums are actually paid, and Medicaid is applied for within the transfer's disqualification period, there is a serious risk that the matter will go to a fair hearing, or beyond. Under these circumstances, we think the practitioner ought to consider other ways of drafting an income-only trust, consistent with the dual objectives of retention of some control by the Grantor, and the need for prudent Medicaid planning.

In this case, counsel for Appellant made the wise choice not to file for an Article 78 to recoup the eight months of benefits which as a practical matter were at issue at the time the decision was rendered.

The Appellant at this Fair Hearing was represented by Michael O'Connor, Esq., of Syracuse, NY.

Endnotes

1. *See* Chapter 41, §§ 85 and 86 of the Laws of 1992, adding EPTL 7-3.1(c) and S.S.L. § 369.3, respectively; and 92 ADM-45.
2. 969 S.W.2d 746 (Mo., 1998).
3. 825 P.2d 1295 (Okla., 1991).
4. 29 A.D.2d 410, 414 (1st Dep't 1968).
5. 36 Misc. 2d 1064, 1065 (Sup. Ct., Erie Co. 1969).
6. *See also* 92 ADM-45.
7. 213 A.D.2d 185 (1st Dep't 1995).
8. 18 N.Y.C.R.R. § 360.4.5(d).
9. (App. Div. 4th Dep't) 1998 Slip. Opin., 11944.
10. *In re James H.,* (November 1997); *In re Catherine M., (*February 1998); and *In re Laura S.*, (June 1999).

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Legislative News

By Howard S. Krooks and Steven H. Stern

Update on Organ Donation in New York

Howard S. Krooks

On October 4, 2000, Governor Pataki signed into law a bill (A11207) permitting a health care proxy to include the principal's wishes regarding organ and tissue donation. As we know, the Health Care Proxy Law found in New York Public Health Law § 2981 allows an individual to appoint a health care agent to make any and all health care decisions, including those regarding life-sustaining treatment, in the event that the individual can no longer make such decisions for him or herself. However, prior to the recent change in the law, an individual could only indicate his or her desire to make a gift of all or part of the body in one of the following ways: 1) by executing a will. In this case, the gift becomes effective upon the death of the testator without waiting for probate. If the will is not probated, or if it is declared invalid for testamentary purposes, the gift, to the extent that it has been acted upon in good faith, is nevertheless valid and effective; 2) by executing a document other than a will. The document, which may be a card designed to be carried on the person, must be signed by the donor in the presence of two witnesses who must sign the document in the donor's presence. Delivery of the document of gift during the donor's lifetime is not necessary to make the gift valid. The gift becomes effective upon the death of the donor; and 3) by completing the form on the reverse side of one's driver's license and having two witnesses sign.

The new provision amends § 2981 of the Public Health Law by adding a new paragraph (f) to subdivision 5 as follows: "[a] health care proxy may include the principal's wishes or instructions regarding organ and tissue donation. Failure to state wishes or instructions shall not be construed to imply a wish not to donate." Thus, practitioners who draft health care proxy forms for clients should indicate on the form whether the donor wishes to make a gift to a specific donee and what should happen in the event that the donee is unable to receive the gift, for whatever reason. In addition, the donor should indicate whether he or she wishes to make a gift of a particular organ. Fortunately, the new legislation makes it clear that the failure to document one's wishes on a health care proxy does not mean the person does not wish to donate organs. Health care providers may still rely on the traditional means of indicating one's intentions in this regard.

Steven H. Stern

It was noted in the sponsor's memorandum in support of the legislation that over 5,000 people are currently on organ transplant lists throughout New York State. By providing a space on the Health Care Proxy form, people will have a greater opportunity to donate their organs. In addition, it is hoped that this will open up the dialogue amongst family members regarding this very important issue. The new law became effective on October 4, 2000.

President Signs the Protecting Seniors from Fraud Act

On November 22, 2000, President Clinton signed the Protecting Seniors from Fraud Act (the "Act"). This new law (formerly known as S.3164 sponsored by Senator Evan Bayh) expresses the sense of Congress that state and local governments should fully incorporate fraud avoidance information and programs into existing programs that provide assistance to the elderly. Specifically, the Act authorizes appropriations of $1 million to the Attorney General for each of the fiscal years 2001–2005 for programs for the National Association of TRIAD (a program originally sponsored by the National Sheriff's Association, International Association of Chiefs of Police, and the American Association of Retired Persons to unite sheriffs, police chiefs, senior volunteers, elder care providers, families, and seniors to reduce the criminal victimizations of the elderly). Under the Act, the Comptroller General of the United States is directed to submit to Congress a report on the effectiveness of the TRIAD program.

The Act also requires the Secretary of Health and Human Services to provide to the Attorney General of each state and to publicly disseminate in each state (including to area agencies on aging) information designed to educate senior citizens and raise awareness about the dangers of fraud, including telemarketing and sweepstakes fraud. In carrying out this mandate, the Secretary is required to inform senior citizens (1) of the prevalence of telemarketing and

sweepstakes fraud targeted against them; (2) how telemarketing and sweepstakes fraud work; (3) how to identify telemarketing and sweepstakes fraud; (4) how to protect themselves against telemarketing and sweepstakes fraud, including an explanation of the dangers of providing bank account, credit card, or other financial or personal information over the telephone to unsolicited callers; (5) how to report suspected attempts at or acts of fraud; and (6) of their consumer protection rights under federal law. The Secretary is directed to determine the means to disseminate the foregoing information, taking into account public service announcements, a printed manual or pamphlet, an Internet Web site, direct mailings and telephone outreach to individuals whose names appear on so-called "mooch lists" confiscated from fraudulent marketers.

Further, the Act directs the Attorney General to conduct a study to assist in developing new strategies to prevent and otherwise reduce the incidence of crimes against seniors. This study is to include an analysis of the nature and type of crimes perpetrated against seniors, with special focus on the most common types of crimes that affect seniors, the nature and extent of telemarketing, sweepstakes, and repair fraud against seniors, and the nature and extent of financial and material fraud targeted at seniors. The study also will include an analysis of the risk factors associated with seniors who have been victimized, the manner in which the federal and state criminal justice systems respond to crimes against seniors, the feasibility of states establishing and maintaining a centralized computer database in the incidence of crimes against seniors that will promote the uniform identification and reporting of such crimes, the effectiveness of damage awards in court actions and other means by which seniors receive reimbursement and other damages after fraud has been established, and other effective ways to prevent or reduce the occurrence of crimes against seniors. Also, the Attorney General is required to include as part of each National Crime Victimization Survey statistics related to crimes targeting or disproportionately affecting seniors, crime risk factors for seniors, and specific characteristics of the victims of crimes who are seniors.

The Act reflects various findings of Congress that older Americans are among the most rapidly growing segments of our society and that the elderly are often the victims of violent crime, property crime, and consumer and telemarketing fraud. According to the National Consumers League, telemarketing fraud costs consumers nearly $40 billion each year.

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Regulatory News 1

By Louis W. Pierro and Edward V. Wilcenski

Retirement Plan Regulations

Louis W. Pierro

In a surprise move on January 11, 2001, the government released substantial revisions to the IRC § 401(a)(9) proposed regulations (1.401(a)(9)-0 through 1.401(a)(9)-8; 1.403(b)-2; 1.408-8; and 54.4974-2). These changes impact everyone who holds IRA or qualified plan retirement assets. Clients should not take any unrequired distribution from their qualified plan until the full impact of the new regulations have been carefully analyzed.

This article is intended to be an overview of the new proposed regulations. The regulations are expected to be finalized on January 1, 2002, however, taxpayers may apply the new proposed regulations beginning January 1, 2001. Practitioners should be aware that the regulations may apply to some decedents who died in the year 2000, and therefore the failure to comply with the old regulations may be rectified if promptly addressed.

Uniform Distribution Table

The new proposed regulations have substantially simplified how one determines required minimum distributions (RMD). Under the new proposed regulations, the participant need only reference the table in the regulations and multiply the factor by the value of the of the plan to determine the RMD for the year. No longer must the planner agonize over whether to recalculate, use the hybrid method, or utilize the non-recalculation method to extend the RMD, maintaining flexibility after the participant's death.

The new tables are extremely generous and will always be better then the old regulations. The only exception we can identify is where a spouse, who is more than ten years younger than the participant, is named as beneficiary. In this case the participant should deviate from the table and utilize the actual joint life expectancy.

Death After the Required Beginning Date (RBD)

Edward V. Wilcenski

After the participant's death, the distribution period is generally the remaining life expectancy of the designated beneficiary. The beneficiary's remaining life expectancy is calculated using the age of the beneficiary in the year following the year of the participant's death, reduced by one for each subsequent year. If the participant's spouse is the sole beneficiary on December 31 following the year of death, the distribution period during the spouse's life is the spouse's single life expectancy. After the spouse's death, the distribution period is the spouse's life expectancy calculated in the year of death, reduced by one for each subsequent year.

If there is no designated beneficiary the distribution period is the participant's life expectancy calculated in the year of death, reduced by one for each subsequent year. If, as of December 31 of the year following the participant's death, there is more than one designated beneficiary and the account has not been divided into separate accounts or shares for each beneficiary, the beneficiary with the shortest life expectancy is the designated beneficiary.

Death Before RBD

In the case of death before the required beginning date for a non-spouse designated beneficiary the default rule is the life expectancy of the designated beneficiary. Thus, absent a plan provision or election of the five-year rule, the life expectancy rule will apply in all cases in which the participant has a designated beneficiary. The five-year rule only applies if the participant did not have a designated beneficiary.

Determination of Designated Beneficiary

The proposed regulations provide that the designated beneficiary is determined as of December 31 of the year following the participant's death. Any beneficiary eliminated by distribution, disclaimer or oth-

erwise during the period between the participant's death and December 31 of the year following the participant's death is disregarded in determining who the designated beneficiary is for calculating the required minimum distributions.

Trust as Designated Beneficiary

The requirements of naming a trust as designated beneficiary is essentially the same, except for one major modification. The trust document need not be submitted to the plan sponsor, and the trust's qualification as a designated beneficiary need not be determined until December 31 of the year following the participant's death. This permits trust reformations to make the trust a designated beneficiary.

Response by President Bush

Tax practitioners applauded the IRS's simplification of an arcane system which had numerous traps for the unwary. While attorneys were burning the midnight oil to understand the new regulations, President Bush issued executive order 12866 on January 17, 2001 which places all temporary regulations on hold for his review until March 17. This author believes that in light of the simplification's benefit to taxpayers, the regulations will not be substantially modified by President Bush.

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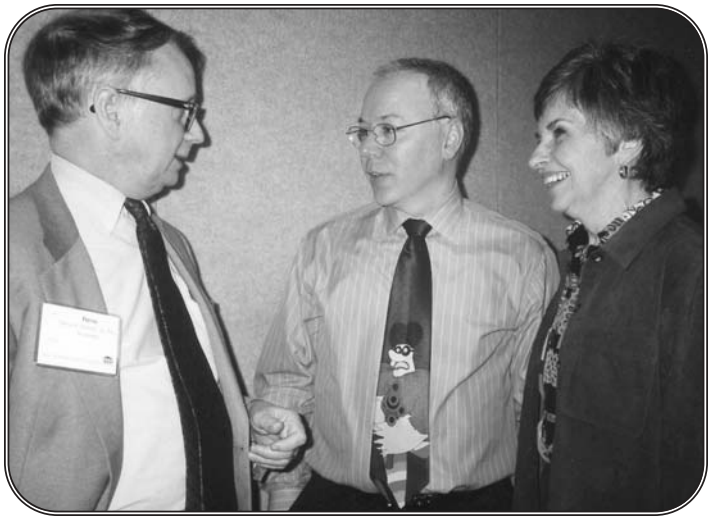

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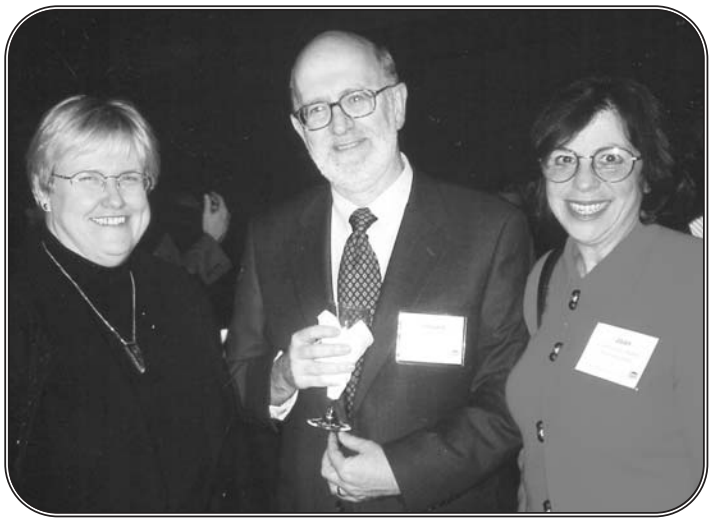

(l-r) Ellen Rosenzweig, Howard Angione and Joan Robert

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Hon. Edwin Kassoff

(l-r) Nancy Lederman and Peter Strauss

(l-r) Bernie Krooks, Laury Gelardy and Lou Pierro

(l-r) Speakers Mark Brody and Joan Robert

Regulatory News 2

IRS Simplifies Minimum Distribution Rules

By Susan B. Slater-Jansen and Avery E. Neumark

On January 12, 2001 the Internal Revenue Service issued revised proposed regulations to § 401(a)(9) of the Code[1] regarding minimum required distributions. The new proposed regulations cover plans qualified under Code § 401(a) (defined benefit, profit-sharing, 401(k) and stock-bonus plans) (under Regulations § 1.401(a)(9)-0 through 8), § 403(b) plans (under proposed regulation § 1.403(b)-2), IRAs (under Proposed Regulation § 1.408-8) and § 457 deferred compensation plans (conforming proposed regulations to be published "shortly").

". . . the main purpose of the new proposed regulations is to simplify the exceedingly complex 'old' proposed regulations which were issued in 1987."

We have summarized the most important provisions of the new proposed regulations below. It should be noted that the main purpose of the new proposed regulations is to simplify the exceedingly complex "old" proposed regulations which were issued in 1987. For the most part, the proposed regulations should simplify the distribution planning of participants in IRAs, qualified plans, and 403(b) plans. *Most* of the changes apply to "individual account" type of plans and not to annuity types, such as defined benefit plans. Therefore, unless noted, this article will describe the changes to the new proposed regulations to individual account plans, such as IRAs, 401(k)s, other defined contribution plans and 403(b) plans.

1. It is no longer necessary that a Designated Beneficiary be in place by a participant's "Required Beginning Date" (RBD). The RBD is still April 1 of the year following: (a) the year a participant of a qualified plan who is a 5% or more owner, or an IRA owner, attains age 70½ or (b) the later of the year a participant of a qualified plan who is not a 5% owner, or a participant of a 403(b) plan attains age 70½ or actually retires.
2. The irrevocable election of recalculation, term certain and hybrid distribution methods as of a participant's RBD have all been eliminated.
3. A minimum required distribution is determined by dividing a plan's account balance as of December 31 of the year *prior* to the distribution year by a life expectancy divisor.
4. **Designated Beneficiary:** The major change in this rule is that the identity of the Designated Beneficiary of a participant must be determined by December 31 of the year *following* the participant's death (this does not mean that an executor can select the Designated Beneficiary). This change allows corrections by disclaimer, timed distributions on account divisions to make the most of the distribution rules.

   For example, if John designates a charity to receive $100,000 of his IRA death benefit, and his sons to receive the balance, the participant would be treated as not having a Designated Beneficiary unless distribution of the $100,000 to charity is made prior to December 31 of the year following his death

   Trust as Designated Beneficiary. In order for a trust to quality as a Designated Beneficiary, it has to:

   (a) be a valid trust under state law, or would be, except that it has no assets until the participant's death;

   (b) be irrevocable upon the death of the participant; and

   (c) provide that the beneficiaries of the trust must be identifiable and be individuals (e.g., charitable trusts, split interests [such as charitable remainder trusts] or otherwise do not quality).

   In addition, a copy of the trust must be delivered to the plan trustee, with an agreement to provide the Trustee with certified copies of any plan amendments *or* a list of all primary, contingent and remainder beneficiaries, must be delivered to the plan Trustee, with a description of the condition of their entitlements, and an agreement to supply a certified copy of any changes to the trust-beneficiary to the plan Trustee. The plan Trustee must be given a copy of the trust upon demand.

On the death of the participant, a copy of the final version of the trust-beneficiary *or* a certified list of all trust beneficiaries (primary, contingent and remaindermen) and a description of their entitlement to benefits must be supplied to the plan Trustee by December 31 of the year following the participant's death.

For the spouse to be treated as the sole Designated Beneficiary of a trust-beneficiary, he or she must be able to withdraw all distributions the Trustees take from the Trust, otherwise the contingent beneficiary(ies)' life expectancies will be included with respect to determining who has the shortest life expectancy. Even if the spouse is the sole Designated Beneficiary of a trust, it appears that the distribution rules after the participant's death will follow those for a "non-spouse" Designated Beneficiary as outlined above (i.e., distributions must begin by December 31 of the year following the year of the participant's death, and cannot wait until the participant would have attained age 70½).

The new proposed regulations make clear that testamentary trusts qualify as Designated Beneficiaries, as well.

5. At his or her RBD, a plan participant must now use the joint-life expectancy table (the "Uniform Table") attached to determine his or her minimum required distribution period (the life expectancy divisor), whether or not there is a "Designated Beneficiary" in place.

   The attached Uniform Table was published in the 1987 proposed regulations, and sets forth the joint life expectancy beginning at age 70 of a participant with an individual beneficiary who is ten years younger then the participant (previously known as the "MDIB" table). Even a participant who has designated his estate or charities or unqualified trusts as beneficiaries, will be able to use the ten-year joint life expectancy Uniform Table during his lifetime to determine his or her minimum required distributions.

   A participant who has a spouse more then ten years younger, can use the spouse's *actual* life expectancy, if the spouse is the *sole* beneficiary of a separate account in a qualified plan or IRA. Each year following the first required distribution year (the actual year the participant attains age 70½ or retires, as long as both are still alive), the participant and his spouse-beneficiary may calculate the participant's minimum required distribution based on their birthday in each successive calendar year (using table VI in Regulation § 1.72-9). The new proposed regulations require a spouse to be alive the *whole* year to use this rule in a distribution year.

   For example, at his RBD, Donald, a widower, had designated his children as beneficiaries of his IRA. After taking three minimum required distributions using the Uniform Table, at age 74 he marries Daisy, age 44. In the year after marrying Daisy, he designates her as beneficiary of his IRA. Donald is now 75, Daisy is 45, and their joint life expectancy denominator from table VI is 38.1 (compared to 21.8 from the Uniform Table). The following year, their joint life expectancy is 37.1. This allows Donald to stretch out his distributions over a much longer period.

6. **Death of Participant Before the RBD**

   With a Designated Non-Spouse Beneficiary: The default rule will now be that a *non-spouse* beneficiary must commence his or her distribution by December 31 of the year following the participant's death and continue over the life expectancy of the beneficiary, determined by the age of the beneficiary in the year *following* the participant's death using table V of Regulation § 1.72-9. The beneficiary's life expectancy will then be reduced by one for each year thereafter (e.g., year 1: 40.6 yrs., year 2: 39.6 yrs., and year 3: 38.6 yrs.). This is the life expectancy distribution option.

   Multi-Beneficiaries With or Without a Spouse Beneficiary: The life expectancy of the *oldest* designated beneficiary of a separate share or account will be used to calculate the distributions; using the same method as for non-spouse beneficiaries.

   No Designated Beneficiary: If there is no designated beneficiary, either named by the participant or designated in the plan (e.g., a plan may require that the beneficiary of a participant who has not designated a beneficiary in a separate beneficiary designation form, will be the participant's surviving spouse or, if none, the participant's children), the remaining plan balance at a participant's death must be distributed by December 31 of the calendar year which contains the fifth anniversary of the date of the participant's death (e.g., if the participant's date of death is January 20, 2001, the final date of distributions under the "five-year rule" is 12/31/06).

The new proposed regulations allow the beneficiaries to elect the life expectancy distribution option or the five-year rule. The new proposed regulations also allow a plan to *require* the five-year rule or the life expectancy distribution option, even if the participant has a Designated Beneficiary.

Spouse as Sole Beneficiary: Minimum required distributions must commence by December 31 of the later of: (a) the year following the participant's death, or (b) the year the participant would have attained age 70½. The spouse is then permitted to use her life expectancy, determined in table V for each year after the participant's death. On the death of the surviving spouse, her estate or her *subsequently* designated beneficiary(ies), can calculate minimum required distributions for each year until the plan is exhausted by using the spouse's life expectancy in his or her year of death (from table V) and subtracting one for each year thereafter.

7. **Death of a Participant After the RBD**

The Designated Beneficiary must be determined by December 31 of the year following the participant's death. The life expectancy denominator will now be computed as follows:

No beneficiary: The participant's life expectancy in the year of death (from table V) is reduced by one for each year following the participant's death.

For example, Jane died at age 76 without designating a beneficiary. Her life expectancy in that year was 11.9. The life expectancy for her estate in the following years will be 10.9, 9.9, 8.9, 7.9 and so forth.

Non-Spouse as Designated Beneficiary: The life expectancy of the beneficiary in the year following the participant's death is determined using table V. This life expectancy is then reduced by one for each year thereafter.

For example, Steven was 80 when he died. His wife, Jean, predeceased him by two years. They had both elected to recalculate their life expectancies, and when Steven died on December 31, 2000, it was expected that the balance in his IRA would have to be distributed by December 31, 2001. Steven had designated a trust under his will for the benefit of his children as Designated Beneficiary for his IRA. In the years after his death, his children will be able to use Steven's life expectancy at age 80 (9.5 from table V) minus one for each year until the benefit is fully distributed (8.5, 7.5, 6.5, and so on).

Spouse as Sole Designated Beneficiary (or Sole Beneficiary of Separate Share, Account or IRA): The spouse's life expectancy is determined by his or her age in each calendar year following the participant's death using table V. On the spouse's death, the spouse's life expectancy in his or her year of death will be reduced by one for each year thereafter. These amounts can be paid to the spouse's estate or to the spouse's subsequently designated beneficiary(ies). Again, a spouse's surviving spouse will not receive the special distribution options as a participant's surviving spouse does.

For example, Douglas designated Cynthia, his surviving spouse, as sole beneficiary of his 401(k) plan. Douglas was 73 and Cynthia was 70 when he died. On December 31 of the year before Douglas's death, his account balance was $470,000. In the year of his death, the life expectancy divisor (from the Uniform Table) was 23.5. The minimum required distribution paid to Cynthia that year was $470,000/23.5 = $20,000. At the end of that year, the account balance was $482,900. The following year, Cynthia is 71. Her life expectancy from table V is 15.3 and her minimum required distribution in that year is $482,900/15.3 = $31,562. The following year, at age 72, she dies. Cynthia had designated their grandson, Ray, as her beneficiary. In the year of her death, the minimum required distribution paid to Ray is based on Cynthia's life expectancy of 14.6. In the following year, the minimum required distribution will be based on the life expectancy factor of 13.6. The life expectancy factors for the following years will be 12.6, 11.6, 10.6, 9.6 and so on.

8. **IRA Rollovers:** Only a surviving spouse can rollover the distribution from a plan to an IRA or from one IRA to another IRA. If the participant had attained his or her RBD, the spouse cannot effect a rollover until the *minimum required distribution* is paid in the year of the participant's death. The spouse can then elect to treat the balance of a participant's IRA as his or her own IRA or can rollover the participant's plan or IRA account balance into his or her own IRA(s). The spouse can designate his or her own beneficiary(ies) and will then be treated as the participant (except that a new spouse, if any, of a participant's surviving spouse will be treated as a non-spouse benefi-

ciary), and if the spouse has not yet attained age 70½, distributions will not be required until his or her RBD (April 1 of the year following the year the spouse attains age 70½).

The new proposed regulations specify that a spouse may effect a rollover *only* if he or she is an outright beneficiary, not if he or she is the beneficiary of a trust, (even if he or she is able to take full distributions from the trust).

9. **Reporting Requirements:** Custodians of IRAs are now to be treated as IRA Trustees to the extent that they *must* report an individual's minimum required distribution to the *participant* and to the IRS each year. This is a *major* change because under the old proposed regulations, most IRA custodians would refuse to perform these calculations for IRA owners who would usually be locked into recalculation, because it was the simplest method. Now IRA custodians must also advise IRA participants that they do not have to take a distribution from a particular IRA, but may aggregate all IRAs *owned* by the same participant and take their minimum required distribution from one or more of them. Rollover-Spousal IRAs may be aggregated with other Rollover-Spousal IRAs, but they may not be aggregated with IRAs owned by the spouse (for distribution purposes).

10. **Effective Date:** The Effective Date for the new proposed regulations is January 1, 2002. However IRA owners *may* use the new distribution rules starting as of January 1, 2001. The IRS has provided a Model Amendment that may be adopted, and if adopted, will allow participants of qualified plans to use the new proposed regulations with respect to distributions as of January 1, 2001. The IRS will not issue determination letters with respect to the adoption of the Model Amendment, and plans being amended now to conform to present IRS requirements should separately adopt the Model Amendment (it is one paragraph long).

    A public hearing on the new proposed regulations is scheduled for June 11, 2001. All comments must be received by the IRS by May 11, 2001.

11. **Certain Rules Have Not Changed:** TEFRA 242(b) elections for qualified plan account balances may remain in effect unless a distribution is taken that does not comply with the election. In the year after the distribution, the full amount of distributions which would have been required had the election not been in place must be distributed.

    There are few changes with respect to annuities from defined benefit plans. Probably the most important rule is that the Designated Beneficiary is the one in place at the annuity starting date, even if this date is later than the Required Beginning Date.

    The penalty for not taking a minimum required distribution is still *50%* of the difference between the minimum required distribution and the amount actually distributed.

". . . the result is that senior citizens, probably the population least qualified to understand the complexities of the old Minimum Distribution Rules (and therefore more likely to be penalized for mistakes) should have a much simpler time now, especially since plan trustees and IRA custodians must now compute the distributions for them."

Conclusion

Although the new proposed regulations are still very detailed, there are a number of questions and inconsistencies that will require corrections, IRS Rulings and Notices to resolve. Nevertheless, the result is that senior citizens, probably the population least qualified to understand the complexities of the old Minimum Distribution Rules (and therefore more likely to be penalized for mistakes) should have a much simpler time now, especially since plan trustees and IRA custodians must now compute the distributions for them. Of course, this does have its downside, since the IRS, which really had no way of policing the Minimum Distribution Rules before, need only add up the Minimum Distribution Requirement reports forwarded by the plan Trustees.

Endnote

1. All references to the "Code" are to the Internal Revenue Code of 1986, as amended.

Uniform Table For Determining Distribution Period

Age of Employee	Applicable Divisor, Maximum Period Certain	Age of Employee	Applicable Divisor, Maximum Period Certain
70	26.2	93	8.8
71	25.3	94	8.3
72	24.4	95	7.8
73	23.5	96	7.3
74	22.7	97	6.9
75	21.8	98	6.5
76	20.9	99	6.1
77	20.1	100	5.7
78	19.2	101	5.3
79	18.4	102	5.0
80	17.6	103	4.7
81	16.8	104	4.4
82	16.0	105	4.1
83	15.3	106	3.8
84	14.5	107	3.6
85	13.8	108	3.3
86	13.1	109	3.1
87	12.4	110	2.8
88	11.8	111	2.6
89	11.1	112	2.4
90	10.5	113	2.2
91	9.9	114	2.0
92	9.4	115 and over	1.8

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TAX NEWS

Medical Insurance and Other Medical Expenses

By Ami S. Longstreet and Anne B. Ruffer

I. Introduction

Ami S. Longstreet

Medical expenses, including health and long-term care insurance premiums, are quite naturally a primary concern of older and elderly clients. The cost of health care has received much media attention during the recent election. Indeed, the proposed tax bill (which did not get passed in the year 2000) contained a provision giving beneficial tax treatment for the payment of premiums for long-term care insurance. The following article presents a general discussion of tax issues as they apply to medical expenses, including health and long-term care insurance premiums, to guide the elder law practitioner in dealing with such issues when raised by clients.

"The cost of health care has received much media attention during the recent election."

A. Medical Expenses, in General

In order to understand how the deduction for medical expenses operates and to know what medical expenses are deductible, it is necessary to define what constitutes medical expenses. According to the Internal Revenue Service, medical expenses include amounts which are paid for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body; transportation costs of a trip primarily for and essential to medical care; qualified long-term care services; and the cost of medical insurance.[1] In addition, a medical expense deduction is allowed for lodging while away from home primarily for and essential to medical care. This deduction is limited to amounts which are not lavish or extravagant and cannot exceed $50 per night per individual.[2] In general, programs prescribed by a physician for treatment of specific diseases are deductible.

If an individual is in a nursing home or a home for the aged because of his physical condition, and the availability of medical care is a principal reason for his presence there, the entire cost of maintenance, including meals and lodging, is deductible. If an individual is in such an institution primarily for personal or family reasons, then only that portion of the cost attributable to medical or nursing care (excluding meals and lodging) is deductible. Payments to perform both nursing care and housework may be deducted only to the extent of the nursing cost.[3]

Anne B. Ruffer

Capital expenditures for home improvements that are added primarily for medical care may qualify for the medical expense deduction to the extent the cost for the improvement exceeds any increase in the value of the property.[4] For example, where a taxpayer is advised by a physician to install an air purifying system in her residence so that the taxpayer, who is suffering from severe respiratory problems, will not continue to suffer from severe breathing difficulties, the deduction available is calculated as follows: if the cost is $800 and the increase in the value of the residence is determined to be only $300, the difference of $500 is deductible as a medical expense. If there is no increase in the value of the residence, then the entire amount would qualify as a medical expense. Any proposed expenditure, therefore, should be reviewed to determine whether it is indeed deductible for tax purposes.

B. Health/Long-Term Care Insurance

Medical expenses also include premiums paid for medical care insurance[5] and premiums paid for qualified long-term care insurance.[6] The deductible amount paid for long-term care insurance is limited as follows for 2001: those individuals 40 years old or younger are limited to $230 in annual long-term care insurance premium expenses; those between the ages of 41-49 are limited to a $430 annual deduction; those between the ages of 50 and 59 can deduct up to $860 annually; those between the ages of 60 and 69 can deduct up to $2,290 annually; and those over 70 can deduct up to $2,860 annually for qualified long-term care insurance expenditures.[7]

Amounts paid as self-employment tax or as employee tax for hospital insurance under the Medicare program are not medical expenses. Similarly, the basic cost of Medicare insurance (Medicare A) is not deductible, unless voluntarily paid by the taxpayer for coverage. However, the cost of extra Medicare (Medicare B) is deductible.[8]

"Clients who itemize deductions and are experiencing a significant increase in their medical expenses (e.g., nursing home expenses) should consider accelerating the payment of some medical expenses before the end of the year so as to group enough expenses together in one year to exceed the 7.5% floor."

II. Deduction for Medical Expenses

Medical expenses may be deducted by an individual on his or her income tax return to the extent that these medical expenses exceed 7.5% of the taxpayer's adjusted gross income and to the extent that such individual itemizes his or her deductions on his or her tax return. As this threshold for deduction is relatively high, the ability to take advantage of the deduction for medical expenses is not available to many taxpayers. Clients who itemize deductions and are experiencing a significant increase in their medical expenses (e.g., nursing home expenses) should consider accelerating the payment of some medical expenses before the end of the year so as to group enough expenses together in one year to exceed the 7.5% floor.

Individuals who are self-employed (this would include partners in a partnership) are granted tax benefits for their payment of health insurance. For the year 2001, self-employed individuals may deduct 60% of the annual cost of health insurance for themselves, their spouses and their dependents.[9] This deduction percentage is slated to increase in later years. It should be noted that this deduction is not allowed for months during which the taxpayer is eligible to participate in an employer-provided health insurance plan (including a spouse's plan). This deduction is more beneficial than the deduction described in the previous paragraph from a tax point of view in that it is not an itemized deduction, but rather it is what is termed an "above the line" adjustment to income. An above the line adjustment is an available adjustment for both individuals who do and do not itemize their deductions, and is not subject to the 7.5% floor discussed above.

A decedent's medical expenses that are paid by the decedent's estate within one year beginning on the day after the decedent's death are treated as paid when incurred and may be deducted on the decedent's individual income tax return for the year incurred if the estate waives an estate tax deduction for these expenses.[10] Alternatively, the estate may deduct the medical expense as a claim against the estate for federal estate tax purposes.[11]

III. Proposed Changes to Deductibility of Long-Term Care Insurance: The Small Business Investment Act of 2000 (HR 2614)

The Small Business Investment Act of 2000 (HR 2614) as passed by the Senate provided for an "above the line deduction" for a percentage of the amount paid during the year for qualified long-term care insurance for a taxpayer, spouse, and dependents, subject to a phase-in. This increased income tax benefit for the payment of long-term care insurance was part of a major tax bill which was not made law in the year 2000. There is speculation that a very similar tax bill may be picked up early in the year 2001 by Congress.

"This increased income tax benefit for the payment of long-term care insurance was part of a major tax bill which was not made law in the year 2000. There is speculation that a very similar tax bill may be picked up early in the year 2001 by Congress."

As discussed above regarding "above the line deductions," these deductions are more advantageous than itemized deductions, as these are deductions available to all taxpayers and not only to those who have the ability to itemize deductions. Further, they are not subject to the 7.5% floor discussed above.

Long-term care and the costs associated with it are of course very important issues for older clients. Long-term care insurance has been receiving much media attention lately, in addition to the heavy marketing of such policies to older clients.

At the time this article was written, President-elect Bush has indicated his possible support of tax legislation in the year 2001. The elder law practitioner should be aware of any tax legislation which may include some additional deductions regarding medical expenses that would be beneficial to their older clients.

Endnotes

1. Internal Revenue Code of 1986 as amended (hereinafter "IRC") § 213(d).
2. IRC § 213(d)2.
3. 2001 Standard Federal Tax Reports, ¶ 12, 543.726, 12, 543.727.
4. IRC Regulation § 1.213-1(e)(1).
5. 2001 Standard Federal Tax Reports, ¶ 12, 543.77.
6. IRC § 312(d)(10).
7. IRC § 312(d)(10), Rev. Proc. 99-42.
8. 2001 Standard Federal Tax Reports ¶ 12, 543.49.
9. IRC § 162(1).
10. IRC Regulation § 1.213-1(d).
11. IRC § 2053.

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Publication News

By Daniel G. Fish

A Review of *When Someone Dies in New York*
By Amelia E. Pohl and Vincent J. Russo
(Eagle Publishing Company of Boca, Boca Raton, Florida, 2000)

The title leaves much to be desired but is an absolutely accurate description of the contents of the book. This is a straightforward, practical description of the steps to be taken after a death in the family. In a matter-of-fact tone it deals with what is, for many, a taboo topic. While it is intended primarily for the lay audience, it is still quite useful for the practitioner. Even though you may have handled numerous estates yourself, do you know the answer to the following questions?

- What special considerations are needed for the cremation of the decedent who weighs more than 300 pounds?
- Who is eligible for military burial and what are the locations of the military cemeteries in New York State?
- What is the approximate cost of an autopsy?
- Does the agent under a health care proxy have the authority to consent to an autopsy?

Many clients are more mystified by the very practical issues surrounding a death than over the probate process. They worry about anatomical gifts, the funeral, the death certificate, giving notice of the death, locating assets and paying bills. This book would be very useful to the layperson who has these very pressing concerns which must be addressed during a time of emotional stress and in a very compressed time frame.

The strength of this book is the very practical approach it takes. In a plain English text, it gives an explanation of the steps necessary for the winding up of the affairs of the decedent. It is also useful in providing an overview of the legal steps which the attorney will take through the probate or administration process.

The book is filled with useful phone numbers, addresses and Web sites. This makes it valuable as a reference guide in your office. It provides a quick way to find out about lost insurance policies, organ donation, registering complaints about funeral directors, filing claims for holocaust survivors, changing title to a motor vehicle and federal employee death benefits. There is a full chapter devoted to an explanation of the estate planning process and a chapter on the psychology of the grieving process.

The book could be improved by a description of the problems encountered when the decedent dies in his or her own home. This book is one in a series. It is available for the States of Arizona, California, Florida and Illinois. Editions in other states are pending.

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He has authored several articles on the legal issues of elder law. He has been quoted in the *New York Times*, *Business Week*, *Fortune* and *Lawyers Weekly USA*. He has conducted seminars for Time Warner, PaineWebber, Champion International, HBO, Ciba-Geigy, Consolidated Edison, The Alzheimer's Association, TIAA-CREF, William Doyle Galleries, Lenox Hill Hospital, Ogilvy and Mather, Chase Manhattan Bank and Conde Nast.

Advance Directive News

The Religious and Cultural Perspective

By Ellen G. Makofsky

As attorneys in New York State, we tend to advise clients who represent a wide spectrum of religious and cultural backgrounds. As elder law attorneys, we need to be particularly sensitive to the existence of these different cultural and religious perspectives[1] when discussing and drafting advance directives. Religion and cultural upbringing are intertwined with the individual's perspective on surrogate decisionmaking. The elder law attorney should not be seduced into believing that because the client was born and raised in the same geographic area, the attorney and client share a value system regarding advance directives or provisions regarding medical care.[2]

We need to resist the immediate autocratic mode. We need to question and elicit information from the client in order to create documents that reflect the client's beliefs. Understanding the underpinnings of the client's belief system or the conflicts within those value systems can be very helpful.

Catholicism rejects both euthanasia and suicide but does not reject, out of hand, advance directives. Catholics often have strong opinions about advance directives. Many practicing and non-practicing Catholics set a stricter standard for themselves regarding end-of-life decisionmaking than the teachings of the Catholic Church require. In a pastoral letter, Bishop John R. McGann, D.D. Bishop of the Rockville Center Diocese, New York, speaks about finding a middle ground in regard to dying where "death is not directly caused and dying is not unnecessarily prolonged."[3] He explains the Church's position by stating that:

> . . . it is morally acceptable—and often an act of love—to forego or withdraw technologies and treatments aimed at prolonging life (including medically-assisted respiration, dialysis, nutrition and hydration) when the patient or health care agent comes to the conscientious judgment that it offers little reasonable benefit, or is an unreasonable burden to the patient. This is a long-standing teaching of the Catholic Church.[4]

Bishop McGann further encourages the preparation of a health care proxy to express directly how health care decisions should be made if the individual is no longer able to make his own decisions.[5] Prior to drafting an advance directive for a Catholic, it can be useful to encourage the client to have a discussion with his parish priest. It might be helpful to include in the advance directive the wish that no medical decision be made which will result in an unnecessarily prolonged death.

The Jewish tradition similarly rejects euthanasia and suicide. Jewish law looks to distinguish between active euthanasia (some overt physical contact which hastens the patient's death) and letting nature take its course (the removal of any existing factor which serves only to impede the patient's otherwise imminent death).[6] There is much debate among the different movements within Judaism about where the line is drawn between euthanasia and letting nature take its course. [7] In regard to the issue of withdrawing artificial nutrition or hydration, one commentator put it this way:

> If the patient is a hopelessly dying patient the physician has no duty to keep him alive a little longer. He is entitled to die. . . . The physician is not really hastening the death; he has simply ceased his efforts to delay it.[8]

On the other hand, some Orthodox Jews see removal of artificial hydration as euthanasia, believing that there is no time when general supportive care including food and water can be withheld or withdrawn.[9] The Orthodox tradition provides for less patient autonomy in regard to medical decisionmaking, the idea being that a rabbi is better equipped to determine where the line is drawn between euthanasia and the forces of nature. Consequently certain Orthodox Jews believe[10] that a heath care proxy should appoint a rabbi to rule on medical issues concerning the incapacitated person.[11] In order to comply with the religious perspective here, the elder law attorney might suggest that the appropriate advance directive for the Orthodox Jew is a Halachic Living Will.[12]

Understanding the client's cultural and religious perspectives is also necessary where we draft health

care proxies that adhere to the standard New York State form. Clients, rather glibly, often say they don't want artificial nutrition and hydration, or they want to "pull the plug." They are not facing a health care crisis then and often these comments are not the result of great thought. If the elder law attorney focuses on probing questions to draw out contemplative and reflective responses, the client is quite often able to sort out his own cultural and religious perspective thereby putting him in a better position to advise his health care agent of his real wishes.

Understanding cultural mores is also important to the elder law attorney. Not all cultures value the right of patient autonomy and self-determination. To many of us the idea that someone might not want to take control of his own destiny is an anathema but all cultures do not share the same values. For example, certain Asian groups and Mexican-Americans come from cultures with strong traditions that focus on the family as the predominant unit rather than the individual. There is much family involvement in health care decisionmaking. Children are expected to care for their parents. A client from this cultural background is not looking for autonomy, because it is perceived as isolating and burdensome.[13] A client with these cultural beliefs usually wants others designated to do the decisionmaking.

To properly represent the client, the elder law attorney must examine his own religious and cultural beliefs to determine whether a conflict exists. Where the belief system or values of the attorney are in conflict with those of the client, the attorney should examine whether he can effectively and competently provide advice and counsel to the client. In some cases the attorney may have an ethical obligation to remove himself from the representation.

An awareness of differing cultural and religious perspectives will give elder law attorneys new insights helpful discussing and drafting advance directives which comport with the beliefs and needs of clients and their families. I urge you to examine them.

Endnotes

1. The purpose of this article is not to provide a survey of all religious beliefs and cultural mores, but rather to highlight some differing beliefs to raise the attorney's consciousness in regard to differing perceptions about advance directives.
2. Stuart D. Zimring, *Multi-Cultural Issues in Advance Directives* 12 NAELA Quarterly (Summer 2000).
3. Most Reverend John R. McGann, D.D., *Comfort My People Finding Peace as Life Ends*, 10 (February 23, 1997).
4. *Id.* at 11.
5. *Id*. at 13.
6. W. Gunther Plaut and Mark Wahofsky, *Teshuvot for the Nineties,* 343-346 (1997).
7. Plaut and Wahofsky, *supra* at 355.
8. Salomon B. Freehoff, *Allowing a Terminal Patient to Die,* American Reform Response, 260 (W. Jacob ed. 1956).
9. Fred Rosner, *Hospice, Medical Ethics and Jewish Customs,* 7 The American Journal of Hospice & Palliative Care (July/August 1993).
10. One Orthodox Jewish advocacy group, Agudath Israel, opposes the standard New York State form for health care proxies, believing that the document accords too much authority to the agent to decide the fate of the patient.
11. Rabbi Zev Schostak, *Is there Patient Autonomy in Halacha?* 22 ASSIA A Journal of Jewish Medical Ethics and Halacha, May 1995 at 26.
12. Halachic Living Wills are available from Agudath Israel of America, 84 William Street, New York, NY 10038, telephone (212) 797-9000.
13. Zimring, *supra* at 12-13.

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Ms. Makofsky is a member of the New York State Bar Association (NYSBA) and serves on its Elder Law Section's Executive Committee. She is Chair of the Health Care Committee of the Elder Law Section. 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).

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Ms. Makofsky writes on elder law and trust and estate topics frequently and co-authored "Balancing the Use of Public and Private Financing for Long-Term Care" and "The New Look of Long-Term Care Financing in the '90's" which appeared in the Journal of the American Society of CLU & ChFC. Ms. Makofsky has appeared on the radio and television and is a frequent guest lecturer and workshop leader for professional and community groups.

Capacity News

In a Probate Proceeding, Where the Issue Is the Testator's Capacity at the Time of the Execution of His Will, When Will a Court Grant Summary Judgment?

By Michael L. Pfeifer

"It is well established that summary judgment is a drastic remedy, the procedural equivalent of a trial, and should not be granted where triable issues of fact are raised that cannot be resolved on conflicting affidavits (citations omitted)."[1] In this article, we will address the following issue: in a probate proceeding where the testator's capacity is questioned, when will courts grant summary judgment? We will also discuss summary judgment involving the corollary issues of undue influence and fraud, which seem to be raised whenever the issue of capacity is broached.

We start with CPLR 3212(b), which states:

> Supporting proof; grounds; relief to either party. A motion for summary judgment shall be supported by affidavit, by a copy of the pleadings and by other available proof, such as depositions and written admissions. The affidavit shall be by a person having knowledge of the facts; it shall recite all the material facts; and it shall show that there is no defense to the cause of action or that the cause of action or defense has no merit. The motion shall be granted if, upon all the papers and proof submitted, the cause of action or defense shall be established sufficiently to warrant the court as a matter of law in directing judgment in favor of any party. Except as provided in subdivision (c) of this rule the motion shall be denied if any party shall show facts sufficient to require a trial of any issue of fact. If it shall appear that any party other than the moving party is entitled to a summary judgment, the court may grant such judgment without the necessity of a cross-motion.

"Although summary judgment is rarely granted in probate proceedings, such relief should not be withheld where the proponent has established a prima facie case in favor of probate and the objectant makes mere conclusory allegations which fail to raise triable issues of fact."[2] Motion for summary judgment was granted where "[t]he only paper submitted in opposition to the motion was respondent's bill of particulars, verified by her attorney, a person with no personal knowledge of the particulars stated therein.[3] In addition, the particulars are so conclusory and devoid of detail that they would not have satisfied respondent's burden even if verified by a person with actual knowledge of the underlying facts.[4]

In re Antoinette[5] is interesting because it illustrates the factual proof that might be submitted to oppose a motion for summary judgment by a proponent of a will requesting that claims of undue influence be dismissed:

> Petitioner's initial contention, that summary judgment should have been granted, is meritless, for the affidavits submitted in opposition thereto contain factual averments which, when taken together, circumstantially support an inference that decedent's execution of the July will was the result of petitioner's exertion of a subtle, but pervasive, form of coercion and influence, by which she overwhelmed and manipulated decedent's volition to advance her own interests (see, Matter of Walther, 6 N.Y.2d 49, 53-54; Matter of Burke, 82 A.D.2d 260, 270; Matter of Kaufmann, 20 A.D.2d 464, 482-483, affd 15 N.Y.2d 825). No single circumstance is dispositive in this regard; rather, it is the confluence of many factors - including the nature of decedent's relations with petitioner, respondents and her attorney of long standing (see, Matter of Burke, supra, at 272-273), and her lack of involvement in fiscal matters, prior to the events at issue; the abrupt and otherwise unexplained changes in decedent's behavior, beliefs and attitudes, culminating in a radical alteration of her testamentary disposition, shortly after petitioner began taking an active role in decedent's

> day-to-day affairs (see, Matter of Elmore, 42 A.D.2d 240, 242); petitioner's sudden intense interest in decedent's financial circumstances, and the fact that she was overheard actually pressing her 90-year-old aunt to take certain actions with respect thereto; and decedent's apparent uncertainty and lack of understanding of some of the transactions she purportedly sought to effect with petitioner's assistance—that suggests that the July will does not truly reflect the independent testamentary intentions of decedent. Considered collectively, these elements demonstrate not only that petitioner had the motive and the opportunity to influence decedent, but that she actually wielded that influence (see, Matter of Walther, supra, at 55) by, inter alia, Page 764 convincing decedent that those she had formerly trusted were stealing from her and were improperly managing her property (see, Matter of Kaufmann, supra, at 482-485).

Where the movant fails to obtain a motion for summary judgment initially, he may be able to obtain success upon completion of discovery proceedings.[6] The mere existence of a confidential and fiduciary relationship between a testator and a beneficiary does not create an issue of fact for the jury. The objectant must also show that the beneficiary was somehow involved in the drafting of the testator's will. If he does so, "although . . . [this] . . . does not shift the burden of proof on the issue of undue influence, it places the burden on the beneficiary to explain the circumstance of the bequest. (Citations omitted). The adequacy of the explanation is a question of fact for the jury."[7]

In order to avoid a motion for summary judgment dismissing a claim of undue influence, the opponent must show that undue influence was possible:

> [T]he record reveals that the Boltons seldom visited decedent, had no control over her daily activities or financial affairs and did not participate in the 1993 will making; further, decedent contacted petitioner to make a new will prior to the Boltons' visit. . . . The record is clearly devoid of any evidence that the Boltons had an opportunity to exercise undue influence over decedent or, as importantly, that they actually did so.[8]

In re Coniglio[9] is interesting because the testator left his estate to a non-relative and was survived by 23 distributees, 12 of whom filed objections. The court said

> The record establishes that the will was duly executed pursuant to the formal requirements of execution and attestation set forth in EPTL 3-2.1. There is a presumption of regularity because the attorney-draftsman supervised the will's execution and objectants failed to overcome that presumption.
>
> The record further establishes that at all relevant times, including the time when the will was executed, decedent possessed the capacity required by EPTL 3-1.1 to make a will. He knew the nature and extent of his property and 'those who would be considered the natural objects of [his] bounty,' and he understood the nature and consequences of executing the will. The proof establishes that decedent, despite his age and reclusiveness, was 'of sound mind and memory' when he executed the will.
>
> Lastly, the record establishes that the will was not the product of undue influence or fraud on the part of proponent. A mere showing of opportunity and motive to exercise undue influence is insufficient to present a triable issue of fact, without evidence that undue influence was actually wielded. Unsubstantiated and conclusory allegations are also insufficient to raise a triable issue of fact whether proponent knowingly made a false statement that caused decedent to execute a will that disposed of his property in a manner different from the disposition he would have made in the absence of that statement.[10]

In re Delyanis[11] is interesting because the court below granted summary judgment to the proponent of the will with respect to all of the issues raised by objectant: capacity, undue influence and fraud. On appeal, the Second Department affirmed summary

judgment with respect to capacity finding "no basis for the appellants' contention that the testator lacked the testamentary capacity to execute a new will . . . nor is that any evidence that the will was not duly executed."[12] However, the Court reversed on the issues of fraud and undue influence saying, ". . . [T]here was sufficient circumstantial evidence of fraud and undue influence to warrant a trial on those questions. Christine Rivera had both the motive and the opportunity to exert undue influence over the decedent and to commit fraud. (citations omitted)."[13] The facts alleged as stated by the court were as follows: once the testator moved in with her daughter, Christine Rivera, the testator's son, the objectant therein, was virtually shut out of his mother's life. Christine had given her mother false information about the objectant's actions towards their mother, as did the attorney who supervised the execution ceremony. (This attorney also was representing Christine at the same time she supervised the execution of the codicil in question.) The codicil disinheriting the objectant was executed two months after the testator moved in with Christine.

In re Hollenbeck[14] is instructive because it sets forth the various burdens of proof the Court uses to reach its holding and details the factual underpinnings of its decision. The burden of proving testamentary capacity, of course, rests on the proponents. The draftsman and his secretary have testified that the decedent was perfectly competent to make a will. Quite apart from their testimony, which the contestants are not prepared to controvert, and the presumption of testamentary capacity, which exists until the contrary is established,[15] there are present in this instance many circumstantial indicia which the courts have considered significant as establishing testamentary capacity. The decedent made sensible replies to inquiries,[16] talked intelligently upon ordinary topics and acted intelligently in matters which engaged her attention.[17] She handled details of her own living affairs normally and properly.[18] She was capable of transacting her business affairs properly,[19] did in fact conduct her affairs in an intelligent and satisfactory manner until the time of her death,[20] and, as far as the record shows, her friends, business acquaintances, and relatives always treated her as responsible.[21] The contestants are not prepared to offer any direct evidence of testamentary incapacity. Rather, they seek to infer a lack of testamentary capacity from circumstantial evidence, i.e., from the decedent's distress over her husband's death, her age (79 years), her loss of appetite and weight, and her sudden death on the same day she executed her will. As none of these factors individually are inconsistent with testamentary capacity or present a triable issue of fact thereon, their collective effect can be no greater. The decedent's distress over the death of her husband was a perfectly normal reaction, and absent, as here, any indication that it affected her testamentary capacity, it is of no probative value. "The mere fact that decedent died within eighteen hours from the making of the will and was in pain at the time of its making presented no issue" to be submitted to a jury.[22] "Mere old age, physical weakness and infirmity or disease or failing memory are not necessarily inconsistent with testamentary capacity."[23] The last minute change in the testatrix's intent does not stand unexplained. She herself offered a perfectly natural and rational explanation for her change of mind. Even were there proof, and there is none, that the proponent urged or persuaded the testatrix to change her will in favor of herself, there could be no presumption that the proponent had acted improperly. "A person has the right to use any reasonable and legitimate argument to induce another to make a will in a particular way. The giving of advice and the use of argument and persuasion do not constitute ground for avoiding a will by a competent executrix even if the will is made in conformity with the advice so given."[24] Though the contestants have the burden of proving fraud and undue influence,[25] they are prepared to offer no direct or circumstantial proof of either. Concededly, the proponent had both the motive and opportunity to act improperly, but this does not suffice. "It is not sufficient to show * * * motive and opportunity to exert such influence; there must be evidence that [the proponent] did exert it, and so control the actions of the testat[rix], either by importunities which [she] could not resist or by deception, fraud or other improper means, that the instrument is not really the will of the testat[rix]."[26]

Undue influence, which is a form of "coercion and duress"[27] and "a species of fraud"[28] "must be proved, and not merely assumed to exist,"[29] "neither surmise, conjecture nor doubt can take the place of proof."[30] There must be affirmative proof, either direct or circumstantial, that fraud or undue influence was actually exercised or exerted.[31] The contestants are not prepared to offer any direct proof as to fraud or undue influence, nor proof of any circumstances which are not as "equally consistent with the assumption that the will expressed the decedent's own voluntary intent," as with the "hypothesis that the chief beneficiary induced the will by undue influence." "An inference of undue influence cannot be reasonably drawn from circumstances when they are not inconsistent with a contrary inference."[32] Facts must be proved from which fraud or undue influence "result as an unavoidable inference."[33]

"Wills are not to be set aside by juries except for the gravest reasons. A person has a right to dispose of

his property in such way and to such persons as he thinks best. It is only in a case where there is substantial proof of mental incapacity, or of undue influence, that courts or juries may annul his testamentary act."[34] The court is of the opinion that the contestants in this instance have demonstrated no proof of testamentary incapacity, fraud, or undue influence, let alone such "substantial proof" as would warrant submitting any issue to a jury; and that upon the proof demonstrated herein, the court would have no alternative but to direct a verdict in favor of the proponent on each issue.[35] Accordingly, the proponent's motion for summary judgment must be granted, and contestants' objections dismissed.

In re Levy[36] shows the hazards of not having an attorney supervise the execution ceremony. Here summary judgment was granted denying probate on the ground that the codicil was improperly executed.

In re McGurty[37] is interesting because summary judgment was granted where the last remaining witness to a will (who was deceased at the time of the motion for summary judgment) could not remember the execution ceremony. The court reasoned: Here, the testimony of the then-surviving attesting witness did not contradict any statement contained in the attestation clause. At most, in response to leading questions, which were posed and answered in succession rather than read and digested at the leisure of the elderly witness, the witness candidly stated that he could not definitively state that he had an independent recollection as to any of the specifics of an event occurring almost four decades earlier. However, he repeatedly insisted that he knew the decedent well and that the decedent knew that he was executing a will leaving his entire estate to the Society. The witness also consistently stated that he had supervised many will execution ceremonies in his status as rector, that it was his custom to read the entire instrument aloud before it was executed, and that he was confident that he had done so in this case.

The only admissible proof that could be adduced before a jury on the issues of testamentary capacity and due execution are the attestation clause and the deposition of Father Hughes. Based upon this evidence, the court would be obliged to direct a verdict in favor of the proponent.[38] To rule to the contrary would result in denying probate to instruments whenever objections have been interposed and the attesting witnesses candidly cannot recall the specific details about an event which lasted for less than an hour decades earlier. Although the admission of a will to probate is a solemn event, due execution and testamentary capacity must be proved by only a preponderance of the evidence[39] rather than beyond a reasonable doubt because the doors of the courts should be open more easily to carry out a testator's last wishes than the doors of the prisons to incarcerate those guilty of a crime.

In *In re Pennino*[40] the Court granted summary judgment on the issue of testamentary capacity but not on the issue of undue influence. There is no basis for the appellant's contention that the testator lacked the testamentary capacity to execute a new will on April 14, 1997.[41] However, there was sufficient circumstantial evidence of the exercise of undue influence to warrant a trial on that question. The proponent of the will, Kathleen Marino, had both the motive and the opportunity to exercise undue influence, and there is evidence that she may have utilized such influence.[42] Indeed, Marino kept her marriage to the testator a secret from the testator's children. Further, she was instrumental in the expeditious execution of the new will three days after the wedding and one month before the testator died.[43]

In *In re Spangenberg*,[44] the court granted summary judgment on the issues of fraud and undue influence but not on the issue of testamentary capacity.

> There is, however, an issue of fact concerning the decedent's testamentary capacity. Around the time the will was executed, the decedent's medical records revealed a diagnosis of delerium, with symptoms of confusion, disorientation, and significant mental impairment. Moreover, the will purportedly devised property which had already been transferred at the time the will was executed. Under these circumstances, the court properly denied summary judgment dismissing the objection which alleged lack of testamentary capacity (see, Matter of Alberts, 87 A.D.2d 671).[45]

In re Sweetland[46] has some interesting factual twists. However, the court granted summary judgment to the proponent.

> Initially, respondent contends that deposition testimony of Perkins and his secretary demonstrates an issue of fact as to whether the will was properly executed. In this respect, respondent points to the fact that Perkins testified that his secretary was present while decedent read the will, whereas his secretary testified that she did not observe decedent read her will. Nevertheless, both Perkins and his secretary clearly tes-

tified that decedent, in their presence, declared the will to be her last will and testament, asked both of them to witness her execution of the will and then signed the will in their presence. Such clearly satisfied the requirements of EPTL 3-2.1 Est. Powers & Trusts (2). Respondent also points to the existence of staple holes at the top of the will as evidence that the will was not duly executed. Regardless of when and why staples were removed from the will (a matter of pure speculation), Perkins' testimony is clear that the will remained in his office after its execution until its offer for probate and, further, that the will in question was the will executed by decedent in his presence on December 8, 1995.

We likewise reject respondent's contention that there exists a genuine issue of fact as to decedent's competency. Respondent gave deposition testimony to the effect that his mother was "kind of childish acting, senile acting [and] [s]he couldn't remember things" and that she "[s]eemed like a five year old at times". Respondent offered virtually no factual testimony to support such conclusory assertions. In contrast to respondent's conclusory assertions, Perkins, who had known decedent for more than 20 years, testified that he was with her for over two hours on the day that her will was prepared, that she was mentally alert, responsive to all of his questions and that "[s]he was as I've known her for over 20 years". Such testimony clearly justified Surrogate Court's determination as to decedent's competency.

Finally, we are of the view that respondent failed to demonstrate by way of admissible factual evidence that an issue of fact existed concerning the claim that decedent's will was the product of the fraud or undue influence of petitioner. At best, the testimony of respondent and his sisters distilled to their unsubstantiated belief that decedent could not and would not do anything without petitioner's permission and, therefore, the execution of the will must have been the result of petitioner's undue influence.

In a footnote the *Sweetland* Court noted that the respondent had not seen his mother for a period of five years prior to her death.

In re Van Pattern[47] is interesting because the court granted summary judgment to the will's proponent on the issue of capacity despite testimony by objectant's medical expert that the testator was incapacitated at the time he executed his will. In reaching its conclusion, the court compared the expert's inability to state his opinion to "a degree of medical certainty"[48] with petitioner's "overwhelming [factual] evidence of the testator's testamentary capacity."[49]

> Considering the undisputed direct evidence of the testator's competence presented by petitioner, and recognizing the inherent limitations in medical opinion evidence in general and the weakness of the particular medical opinion evidence presented by respondent, we are of the view that the general rule in will cases, which gives precedence to the facts when opinion evidence of testamentary capacity is contradicted by all of the facts, applies to this summary judgment motion. Petitioner met the burden as the movant to establish entitlement to judgment as a matter of law (see Zuckerman v City of New York, 49 N.Y.2d 557, 562) and respondent's submission of the opinion of an expert who never examined the testator nor was otherwise involved in the medical history of the case is insufficient to warrant a trial on the issue of testamentary capacity (see, Matter of Vukich, 53 A.D.2d 1029, 1030, supra; Matter of Langbein, 25 A.D.2d 681; Matter of Horton, 272 App. Div. 646, 650, supra).[50]

Conclusion

Where there are no genuine issues of fact for a jury to resolve, courts will grant summary judgment.

Endnotes

1. *In re Raskas*, 213 A.D.2d 718, 719, 624 N.Y.S.2d 279 (2d Dep't 1995).
2. *In re Bartel*, 161 Misc. 2d 455, 613 N.Y.S.2d 798 (Sur. Ct, N.Y. Co. 1994); Cf. *In re Bustanoby*, 262 A.D.2d 407, 408, 691 N.Y.S.2d 155 (2d Dep't 1999).
3. *See Zuckerman v. City of New York*, 49 N.Y.2d 557, 563.

4. *See In re Cioffi*, 117 A.D.2d 860; *In re Allen*, 210 A.D.2d 856, 857, 621 N.Y.S.2d 138 (3d Dep't 1994).
5. 238 A.D.2d 762, 763, 657 N.Y.S.2d 97 (3d Dep't 1997).
6. *In re Bartel*, 161 Misc. 2d 455, 613 N.Y.S.2d 798 (Sur. Ct., N.Y. Co. 1994).
7. *In re Bartel*, 161 Misc. 2d 455, 456, 613 N.Y.S.2d 798 (Sur. Ct., N.Y. Co. 1994).
8. *In re Buchanan*, 245 A.D.2d 642, 643, 665 N.Y.S.2d 980 (3d Dep't 1997).
9. 242 A.D.2d 901, 663 N.Y.S.2d 456 (4th Dep't 1997).
10. *Id.* at 902 (citations omitted).
11. 252 A.D.2d 585, 676 N.Y.S.2d 219 (2d Dep't 1998).
12. *Id.* at 585.
13. *Id.*
14. 65 Misc. 2d 796, 318 N.Y.S.2d 604 (Sur. Ct., Jefferson Co. 1969).
15. *In re Beneway*, 272 App. Div. 463, 467.
16. *In re Case*, 214 N.Y. 199, 203.
17. *Horn v. Pullman*, 72 N.Y. 269, 275.
18. *In re Goeb*, 290 N.Y. 894; *Pettit v. Pettit*, 149 App. Div. 485, 490.
19. 1 Davids, N.Y. Law of Wills, 34, p. 57; *In re Horton*, 297 N.Y. 891, 892; *In re Wolf*, 196 App. Div. 722, 728 (4th Dep't).
20. *In re Lasak*, 131 N.Y. 624, 626.
21. *Marx v. McGlynn*, 88 N.Y. 357, 370; *Lavin v. Thomas*, 123 App. Div. 113, 116 (4th Dep't).
22. *In re Hermanowski*, 279 N.Y. 727, 728.
23. *In re Beneway*, 272 App. Div. 463, 467, *supra*.
24. *Smith v. Keller*, 205 N.Y. 39, 44; *Hagan v. Sone*, 174 N.Y. 317, 320; *In re Walther*, 6 N.Y.2d 49, 55 188 N.Y.S.2d 168 (1959).
25. *In re Schillinger*, 258 N.Y. 186, 192-193.
26. *Cudney v. Cudney*, 68 N.Y. 148, 152; *In re Walther, supra*; *In re Dowdl*e, 224 App. Div. 450, 453 (4th Dep't), *aff'd*, 256 N.Y. 629; *In re Williams*, 19 N.Y.S. 778, 780, *aff'd*, 141 N.Y. 572, *supra*.
27. *Smith v. Keller*, 205 N.Y. 39, 44, *supra*.
28. *In re Smith*, 95 N.Y. 516, 522.
29. *Loder v. Whelpley*, 111 N.Y. 239, 250; *In re Schillinger*, 258 N.Y. 186, 189; *In re Dowdle*, 224 App. Div. 450, 453-454 (4th Dep't), *aff'd*, 256 N.Y. 629.
30. *In re Streb*, 247 App. Div. 556, 560 (4th Dep't); *Dobie v. Armstrong*, 160 N.Y. 584, 594-595).
31. *In re Walther, supra*, pp. 54-55; *In re Moskowitz*, 303 N.Y. 992, 993; *In re Dowdle*, 224 App. Div. 450, 453, *aff'd*, 256 N.Y. 629, *supra*; *Marx v. McGlynn*, 88 N.Y. 357, 370, *supra; Cudney v. Cudney*, 68 N.Y. 148, 152, *supra*.
32. *In re Walther*, 6 N.Y.2d 49, 54.
33. *In re Schillinger*, 258 N.Y. 186, 190.
34. *Hagan v. Sone*, 174 N.Y. 317, 323, *supra*; emphasis supplied.
35. CPLR 3212 N.Y.C.P.L.R.
36. 169 A.D.2d 923, 564 N.Y.S.2d 642 (3d Dep't 1991).
37. 151 Misc. 2d 42, 571 N.Y.S. 848 (Sur. Ct., Bronx Co. 1990).
38. *In re Cottrell, supra*; *In re Watts, supra*; *In re Bright, supra*; *In re Zipkin, supra*.
39. *In re Kumstar*, 66 N.Y.2d 691.
40. 266 A.D.2d 293, 698 N.Y.S.2d 265 (2d Dep't 1999).
41. *See In re Kumstar*, 66 N.Y.2d 691, 692.
42. *See In re Walther*, 6 N.Y.2d 49.
43. *See In re Delyanis*, 252 A.D.2d 585.
44. 248 A.D.2d 543, 670 N.Y.S.2d 48 (2d Dep't 1998).
45. *Id.* at 544.
46. __ A.D.2d __, __ N.Y.S.2d __ (3d Dep't 2000).
47. 215 A.D.2d 947, 627 N.Y.S.2d 141 (3d Dep't 1995).
48. *Id.* at 948.
49. *Id.* at 950.
50. *Id.* at 950.

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GUARDIANSHIP NEWS

Guardianship and Trusts

By Robert Kruger

The idea for this subject was sparked by an article in the *New York Law Journal* of September 22, 2000 (page 1, col. 1) by G. Warren Whitaker entitled "Using Revocable Trusts in New York: Why not?"

I take the liberty of quoting from the article this page (page 6, col. 2-3)

> **3 Revocable Trust:** A revocable trust is the preferred vehicle for holding the assets of an incapacitated person for an extended period of time. The powers of trustees, as well as the appointment of co-trustees and successors, can all be clearly set forth in the instrument and amplified by many provisions of New York law. The extent of the trustee's authority is generally not questioned.
>
> A recent New York Supreme Court case casts a pall over the use of revocable trusts during incapacity. *In Matter of Elsie "B"* (Sup. Ct., Albany County, March 1, 1999; aff'd App. Div. 3d Dept. May 11, 2000), an elderly woman created a revocable trust and named her attorney and her brother as the trustees. Trustees were not given the power to appoint successors. She added most of her assets to the trust and later became incompetent. The grantor's brother was then appointed as her guardian, solely to deal with the few assets that she had not transferred to her trust. After his appointment, however, he claimed that as guardian he possessed the grantor's right to amend the trust agreement, which he purported to do in order to appoint his sons as successor trustees. The brother then died and the nephews claimed to be appointed successor trustees. The Supreme Court upheld (and the Third Department affirmed) the guardian's power to amend the trust pursuant to § 81.21 of the Mental Hygiene Law.
>
> Unless this case is overturned on further appeal or overruled by statute, it represents a threat that a revocable trust which was carefully crafted by a grantor to accomplish his or her wishes during incapacity may be freely amended by a guardian after the incapacity occurs. One way to avoid this result might be to specifically provide in the revocable trust agreement that only the grantor may amend the agreement, and not a guardian appointed for the grantor.

"Are Mr. Whitaker's concerns, concerns I might add shared with many of his colleagues in the Trusts and Estates Section, well taken? My conclusion is probably not."

Are Mr. Whitaker's concerns, concerns I might add shared with many of his colleagues in the Trusts and Estates Section, well taken? My conclusion is probably not. Since *Elsie B* appears to be the sole reported decision on the amendment and modification of trusts under Article 81, this article is very much an opinion piece, albeit colored by experience in two Article 81 proceedings (unreported) where trusts were amended and modified in certain respects to the unquestioned benefit of the IP.

The Third Department stated (contrary to Mr. Whitaker's characterization) that *Elsie B* involved the exercise by a court-appointed guardian of powers to name successor trustees retained by the grantor in the governing instrument of her revocable trust. Now that she was permanently incapacitated and had a guardian (both personal needs and property management), the guardian acting as her Surrogate named successors. Limiting the question, as the Third Department explicitly did, to the power of the guardian to exercise retained powers and name successor trustees, I submit that there is nothing wrong and, indeed, positive good in that. This is particular-

ly true since the successors were the actual objects of her bounty, having significant beneficial interest in the trust corpus upon her death.

The Third Department noted that MHL § 81.21(a)(6) grants guardians the power to create "revocable or irrevocable trusts" with property of the IP, inferring that amendment or modification of existing trusts in reliance upon retained powers is clearly within the powers granted by statute.

The Third Department did not refer to MHL § 81.16(b), in the section entitled "Dispositional alternatives" (perhaps because the procedural posture of *Elsie B* was a post appointment application to ratify the prior unilateral appointment of successor trustees). This section empowers a Court, without appointing a guardian, to ". . . authorize, direct, or ratify any contract or trust . . ." suggesting to the author at least that the power to create a trust certainly encompasses the power to amend or modify a trust.

Understandably, there is concern that a complicated estate plan be undisturbed by the ministrations of an assumedly less sophisticated judiciary. This is hardly a likely outcome, because those with considerable wealth and complicated estate plans also have experienced counsel and protective legal arrangements that anticipate most outcomes. The problem in *Elsie B* was the apparent estrangement between her attorney (trustee) and her brother (the other trustee besides Elsie). The brother, as guardian, must report to and account to the Court annually. There is no mention of self-dealing by the brother in the decision. If there were, would not the attorney, who remained as trustee, have the ability to report this to the Court?

The risk of amendment to dispositive schemes of other grantors seems to underline Mr. Whitaker's alarm. Yet, the trustees cannot act unilaterally. *In re Shah*[1] resonates here. No gift giving or transfer of assets without judicial supervision is possible. Conversely, if a competent reasonable individual would make gifts or transfer assets, why should a trust, rather than a will, frustrate the gift? Of course, this begs the troubling question: would a court depart from a trust dispositive scheme or from a testamentary plan contained in a will? The answer, I suspect, is not very likely, but that, of course, is my speculation.

There are two cases the author was involved with where a revocable trust in one case, and an irrevocable trust in the other, were modified. In neither instance was the object of the petitioner in the guardianship proceeding to change the dispositive scheme.

In the case of *Lucy M.*, the attorney-fiduciary of the grantor (who was probably seriously cognitively impaired when the trust was created), negligently (but not maliciously) permitted the attorney's assistant to remove furniture in the residence of the IP in preparation for moving his family into the apartment. Amazing, isn't it? Obviously, the attorney was paying no attention whatsoever. The guardianship contest ended with the appointment of a co-fiduciary and the retention of the attorney as co-fiduciary, with the administration of the trust being handled by the new co-trustee. There were, in addition, other amendments to the trust, to tighten the accounting requirements. In this case, I can find no justification for failure to amend the trust.

"Understandably, there is concern that a complicated estate plan be undisturbed by the ministrations of an assumedly less sophisticated judiciary. This is hardly a likely outcome, because those with considerable wealth and complicated estate plans also have experienced counsel and protective legal arrangements that anticipate most outcomes."

In the second case, Jean K, while competent, created a revocable trust with the bulk (but not all) of her assets, naming a major financial institution as her fiduciary. As she declined, the institution had great difficulty in cooperating with, and accepting, the caregiver's directions. While understandable, this forced a guardianship to empower a surrogate decision maker and the Court named as Co-trustee the caregiver's attorney. A personal needs guardian would not suffice, because a not inconsiderable quantity of assets lay outside the revocable trust. Moreover, the institutional trustee continued to resist payment of legitimate (nursing home) bills after the guardianship-co-trusteeship was in place. The trust officer did not realize or accept the fact that legitimate bills had to be paid. She was clueless, as an opinion the bank's attorney freely shared when I sought his assistance. In this matter, the trust did not adequately address the IP's needs. The trust itself was adequate; the administrator of the trust was the problem. After the Guardianship has concluded, a more senior trust officer offered the opinion that the Bank in estates under $1,000,000, would be better served in terminating the trust and turning all

monies over to the guardianship. That opinion begs other questions beyond the purview of this article.

These anecdotes point out two instances where modification of trusts were very much in the IP's interest. I hesitate to generalize from a limited database. I do invite comments from the Bar regarding your experience with trusts in guardianships

As this article is submitted (January 17, 2001) the Chief Judge has shaken up guardianship practice in the Second Department by converting the single judge model to a four-judge rotation, each of the four judges adding guardianship matters to their caseload for a three-month period. I invite comments from the bar on their experience, noting that the judges who sat in guardianship were not invited in several instances to be part of the rotation. The Second Department now has judges who are relative novices in guardianship parts.

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

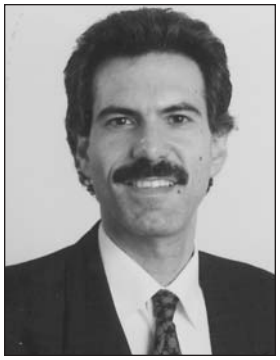
1. 95 N.Y.2d 148 (2000).

Robert Kruger is the Chairman of the Committee on Guardians and Fiduciaries, Elder Law Section of the New York Bar Association. He is also Chairman of the Subcommittee of Financial Abuse of the Elderly, Trust and Estates Section, New York State Bar Association. Mr. Kruger is author of the Chapter on Guardianship Judgments in the book on guardianships published last fall by the New York State Bar Association 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 Article 81 (Guardianship) training course from 1993 through 1997 at the Kings County Bar Association and has experience as guardian, court evaluator and court-appointed attorney in guardianship proceedings. Robert Kruger is a member of the New York State Bar (1964) and New Jersey Bar (1966). He graduated from the University of Pennsylvania Law School in l963 and the University of Pennsylvania (Wharton School of Finance (B.S. 1960).

Public Policy News

The Bush Administration . . . What Lies Ahead

By Ronald A. Fatoullah



After an election that was bitterly contested, and a five-week recount, George W. Bush's biggest challenge is to appeal to both Democrats and Republicans in a Congress that is narrowly Republican. George W. Bush certainly did not receive a popular mandate as final official figures revealed that Al Gore received more than a half million more popular votes than Bush. The days of getting bills through Congress strictly on party lines may be fewer and fewer. The November 2000 election left the 107th Congress with an evenly divided Senate and House that has a six-vote Republican majority. Bush's major campaign themes included Medicare and tax relief, both of which are of great interest to the elder law practitioner and his/her clients.

This article was submitted several months prior to its publication, and much can change in the interim. At the time of this writing, there is much controversy regarding Bush's selection of certain conservative individuals to fill certain cabinet positions. When John Ashcroft was selected by Bush as Attorney General, I heard more than one elder law colleague wonder whether an assault on par with the "Granny Goes To Jail" law will surface at some time during the new administration.

Although this is something we must be prepared for, *I* doubt that this will happen. As Christopher Shays, a leading House moderate and a Republican from Connecticut, declared: "Republican leaders will have to rule from the center, not from the right, or risk losing those of us in the middle . . . if our side chooses to be more partisan, they're going to lose key votes." The checks and balances are very much in place.

The Senate, now evenly divided, has agreed to provide for equal representation of Republicans and Democrats on every committee. This agreement was reached on January 5th between Republican leader Trent Lott of Mississippi and Democratic leader Tom Daschle of South Dakota. This power sharing arrangement is unprecedented in Senate history.

Although Republicans and Democrats are equally represented on committees, Vice President Dick Cheney has the tie-breaking vote on the Senate floor, and can force bills and nominations from deadlocked committees. The full Senate can vote to free a bill or nomination from a deadlocked committee and get them on the Senate calendar.

What wasn't agreed on was how to handle the breakdown of conference committees. At the time of this writing, Republicans were adamant that Democrats not be granted equal votes on conference panels—Republicans did not want to give Democrats that much leverage, as a tie blocks agreements in conferences.

Nevertheless, there are coalitions of Democrats and Republicans that are eager to reach beyond party lines on certain issues. For example, a group of approximately 30 conservative Democrats in the House, known as the "Blue Dog Coalition" has asked Republican leaders to be included in the drafting of legislation dealing with health care and budget policy. Many members of the Blue Dog Coalition vote with the Republican majority on tax, budget and some social issues. Similarly, the Republican "Main Street Partnership" which includes members of the House and Senate as well as several governors, attempts to reach bipartisan solutions on education, the environment, budget policy and Social Security.

In his campaign, Bush pledged to push for legislation to cut taxes by $1.3 trillion over the next decade. Of great concern to the elder law practitioner is the elimination or reform of the estate tax. Estate planning is typically an integral part of an elder law attorney's practice. And, in actuality, Democrats and Republicans are not very far apart on the issue of providing some estate and gift tax relief. A practical approach will likely be to move away from elimination of the estate and gift tax, and to embrace, in a bipartisan way, cuts in these taxes and protections for family farms and small businesses. A very important issue that did not get much press last year, was that estate tax elimination was linked with provisions that provided for a carry-over tax basis for estates above certain dollar limits. Currently, all assets in an individual's taxable estate will receive a tax basis "step-up" to the value at the time of death (or alternate valuation date) for capital gains purposes.

Elder law attorneys may oppose estate tax reform, because the loss of estate tax dollars will probably affect the funding of social programs on which our clients rely. Charitable organizations will likely be up in arms over estate tax reform as gift and estate tax incentives for making charitable donations would be

eliminated or severely watered down. The financial industry may oppose the carry over basis provisions, because most of their clients would find it difficult to prove to the IRS the cost basis of securities that were purchased many years ago. Last year, President Clinton vetoed the Republican legislation that would have entirely eliminated the estate tax.

During the presidential campaign, George W. Bush responded to a question posed by AARP regarding the role he expects the federal government will play with regard to long-term care as follows:

> As our population ages, providing long-term care is one of the most important challenges families will face. Currently, seniors must spend down their hard-earned assets in order to access government benefits. We can do better. I believe that through flexibility, innovation, and providing incentives to purchase private coverage, seniors and their families will know that long-term care benefits will be available when they need them most. The federal government should also provide reliable and comparable information about the quality and cost of care provided by long-term care providers. That way, the policy that best fits a person's health requirements can be chosen.

This sets the stage for reintroduction of some form of "The Long-Term Care and Retirement Security Act of 2000" which was sponsored last year by Senators Grassley and Graham and Representatives Johnson and Thurman. This bill, which had bipartisan support, provided individuals with long-term care needs or their caregivers a $3,000 tax credit to help cover their long-term care expenses. Under this proposal, an individual would have been eligible if he or she was certified by a physician as needing help with at least three activities of daily living, such as eating, bathing, dressing. The tax credit would have been phased in over four years. The credit also phased out by $100 for each $1,000 (or fraction thereof) by which the taxpayer's modified adjusted gross income exceeded the threshold amount of $150,000 for a joint return and $75,000 for an individual return.

The Grassley bill also would have given individuals an *above-the-line* tax deduction for the cost of their qualified long-term care insurance policies (as defined by Health Insurance Portability Act § 7702B(b)). The applicable percentage of the deduction would have been phased-in based on the number of years of continuous coverage that an individual held a qualified long-term care policy. The deduction would have been phased in over three or four years and would have been capped at the age-based deduction levels that currently exist in § 213 of the tax code. In addition, the Grassley bill included strong consumer protection standards for qualified long-term care policies.

There will also likely be bipartisan support for a Medicare prescription drug bill and a patients' bill of rights at some time early into the Bush administration. During the Clinton administration, the Republicans and Democrats proposed vastly different prescription drug bills. The Republican plan relied on private insurance companies to offer prescription drug-only coverage, but this is something the insurers have stated that they would not do. Under this proposal, most seniors would have had to pay for benefits—and a senior living on as little as $12,525 a year would not get any help with the cost of insurance premiums. The Democratic proposal was voluntary, affordable and universal. All Medicare beneficiaries would have been offered coverage with a 50 percent premium subsidy, and would have protected the most vulnerable Medicare consumers by paying all costs for those with the lowest incomes. At the time of this writing, the parties have not yet come together on the details of a prescription drug benefit.

Last fall, Rep. Norwood, Republican from Georgia and Rep. Dingell, Democrat from Missouri, got together and compromised on a bill that would provide consumer protections in managed care, commonly referred to as the Norwood-Dingell bill. This bill contained of the provisions from an earlier bill proposed by Dingell, but with a few exceptions. For example, some restrictions on damage awards were added to the "right to sue" provision and the ombudsman provision was dropped totally. The Senate, which is now evenly divided, is more likely to support the Norwood-Dingell legislation this year, but they will first have to get it on the Senate calendar and avoid filibuster by the right wing of the Republican party.

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SNOWBIRD NEWS

Florida's "Head in the Sand" Approach to Post-Medicaid Eligibility Treatment of Income for Medical Expenses

By Julie Osterhout

As we shepherd our clients through the efforts and hurtles of obtaining eligibility for Medicaid institutional care or other Medicaid home or community-based programs, we need to look to the benefits that can be obtained or retained after a successful application for eligibility. One of the principal resources that an individual has after obtaining Medicaid eligibility is their income stream. This income can be utilized under various allowable deductions. One of the beneficial uses of the institutionalized individual's income include the diversion of the income to the spouse and dependent family for their needs. There is also the nominal personal needs allowance of $35 in Florida. Florida has made no provision for the federally authorized deduction by the individual for medical expenses. This article will review this area as provided under federal Law and Florida's ostrich-like approach.

42 U.S.C. § 1396(a) provides for various rights that an individual has in their income even after they have obtained approval to receive the Medicaid nursing home benefit or home-based services under a waiver program. This statute sets out the requirements that must be provided for in the State's plan for administration of the Medicaid benefits. In particular, § 1396(a) provides that

> with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, . . . there shall be taken in account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including —. . .
>
> (ii) Necessary medical or remedial care recognized under state law, but not covered under the state plan under this Title, subject to reasonable limits the state may establish on the amount of those expenses.[1]

These rights enable the individual to utilize their income to pay for additional items such as additional health care coverage like supplemental health insurances, deductibles and co-payments. It also allows the individual to use their income to pay for medical expenses that are not covered under the state plan. This may include expenses that do not have adequate reimbursement rates or procedures and equipment or treatments that are not covered at all. The logic to this policy choice becomes apparent as the income can be used to supplement an individual's needs and private insurance can be used to cover medical expenses maybe even reducing the load on the government benefit programs.

Federal law requires that the state's plan provide for this post-eligibility treatment of income. In 42 C.F.R. § 435.725 the amounts that are *required* to be deducted from post eligibility income are described in more detail, which include the personal needs allowance, maintenance needs of the spouse, maintenance needs of the family and medical care expenses not subject to third party payment. It is these medical care expenses that are not subject to third party payment for which Florida makes no provisions.

Florida has an administrative rule that addresses post-eligibility treatment of income. This rule provides for all of the areas required under federal statute and rule, but for the deductibility of the additional medical care expenses.[2] On March 5, 1999, HCFA issued a transmittal notice to the states in Region IV, which includes Florida, directing them to review their state plan as to this issue, because they were not in compliance with federal law. As of this date, Florida still has taken no action to bring their program within compliance of federal law in the area of post-eligibility treatment of income for medical and remedial care expenses.

When an individual goes through the application process to obtain Medicaid institutional benefits, the Department of Children and Families (the administrating body in Florida) dutifully asks the questions as to whether or not the individual has any secondary insurances, as well as any unpaid medical expenses. Upon completion of the application, no matter what the answers are by the individual as to these questions, there is no effect on the determination on the patient's responsibility to pay to the nursing home. In effect, the State of Florida does not

allow or provide for the federally required deductions for medical expenses, which reduce the patient's responsibility to pay their income to the nursing home. The state case workers in Florida have been routinely telling applicants to cancel their supplemental insurance as they no longer need it and can no longer afford it.

In order to address this issue, our office has just completed two administrative appeals. The result for our cases and two others in Florida have been orders recognizing the legal requirement by the State of Florida to provide for these deductions. The two cases we have taken through the administrative hearing process involved past dental bills, as well as insurance premiums for supplemental health insurance.

In the most recent discussions with counsel for the Department of Children and Families, some effort is being made to provide for an easier resolution of these actions by the State of Florida. However, at this time the case worker is not empowered by rule or procedure to take into account medical expenses and reduce the patient responsibility amount payable to the nursing home from the patient's income. As a result any efforts to obtain these benefits for your client require a full administrative hearing to prove the various elements of necessity, medical reasonableness and reasonableness of the expense, and the lack of coverage under the state plan. Some items such as supplemental health insurance premiums or insurance deductibles and co-payments require very little proof as it would be recognized that these premiums would not be covered under the state plan and the reasonableness of the insurance rate is not at issue, as these items are not subject to the requirements of necessity or reasonableness. This is a true disservice to the residents of the State of Florida as the monetary value of these benefits are typically small in comparison to the expense of going through the administrative hearing process. It is hoped that the State of Florida will soon recognize the disservice that they are heaping on their citizens who are in a most needy situation, and correct their administrative process, by adopting an administrative rule authorizing their caseworkers to approve these deductions and reduce the patient's responsibility for these expenses.

Counsel for the department in the district that we have brought the test cases has been cooperative and is allowing stipulation to the facts where there is no dispute. She has also been trying to get authority for settlements but this still requires the initial request and additional work through the Department's counsel. The reception on these issues in other districts in Florida is unknown, but a full hearing would likely be required.

One of the side benefits of the State of Florida not having adopted adequate rules to provide for these deductions, is that the state has also failed to establish any limits as to the reasonableness of these expenses. This authority is granted in the federal statute. As a result, Florida has no limits imposed by rules as to the reasonableness of expenses that are deductible and therefore it is left to the creativity of counsel to create reasonableness for the required deductions that are allowed to an individual seeking to retain their income for their own use and benefit.

Endnotes

1. 42 U.S.C. § 1396(a)(r)(1)(A).
2. Florida Administrative Code 65A-1.714.

Julie Osterhout has been practicing law in the Fort Myers, Florida area since 1980. She received her Juris Doctorate in 1980 from Mercer Law School and opened her private practice in 1990. She has concentrated on the laws and issues affecting the elderly since 1982. Her practice includes estate planning, probate, guardianship, asset protection planning and Medicaid qualification. In 1995, Julie was certified as an Elder Law Attorney by the National Elder Law Foundation. Julie is the immediate past chair of the Elder Law Section of The Florida Bar. Julie is a current member of the Board of Directors of the National Academy of Elder Law Attorneys, and was named a Fellow of the National Academy of Elder Law Attorneys in 1997.

Public Elder Law Attorney News

Rodriguez v. City of New York: A Discussion of the Issues Under the ADA and Medicaid Law and Implications for Home Care Services in New York

By Valerie J. Bogart

The form of insurance most relied on by older persons and persons with disabilities for all long-term care services—in nursing homes as well as at home in the community—is Medicaid.[1] The Medicaid program has historically had an institutional bias, with 80 percent of national long-term care expenditures spent on institutional care in 1996.[2] In New York alone, the Medicaid program spent over $6.1 billion on institutional care but only $2.3 billion on various types of community-based care (including $1.3 billion on the personal care program) in fiscal year 1998.[3] Though still biased toward nursing home care, the proportion of Medicaid funds devoted to home and community-based care has grown substantially in the last decade, reflecting a strong consumer preference for care in the community rather than nursing homes.[4] The landmark decision of the United States Supreme Court in *Olmstead v. L.C.*[5] holds considerable promise for expanding the availability of Medicaid-funded services in the community as an alternative to nursing homes. However, in New York and other states in the Second Circuit, the promise of *Olmstead* is sharply undercut by the decision in *Rodriguez v. City of New York*. This article summarizes the two legal issues in *Rodriguez v. City of New York*[6]—under the ADA and under the federal Medicaid law—and their potential impact.

Background

The *Rodriguez* case involved a challenge by Medicaid recipients who have disabilities, many of whom are elderly, to harsh cutbacks in New York's Medicaid "personal care" program, the largest of New York's four Medicaid home care benefits.[7] New York's Medicaid program provides personal care services for up to 24 hours per day to assist persons with disabilities to carry out their normal daily activities, with the number of hours of daily care depending on the individual's needs.[8] In a departure from 20 years of practice, New York suddenly decided that only the need for *physical* assistance would be counted in assessing the amount of personal care to authorize. The verbal cueing and supervisory "safety monitoring" needed by persons with Alzheimer's disease and other cognitive impairments no longer counts. As a result, people with physical impairments are eligible for up to 24 hours a day of personal care, while people with cognitive impairments qualify for, at most, a few hours of care. As the reduced amount of care is not enough to maintain them safely at home, they are forced into nursing homes where they then receive exactly the care they were denied while at home. Furthering this irony, and injustice, is the fact that those who get an adequate amount of personal care service because of the *physical* nature of their disabilities are also provided with any necessary safety monitoring during all the hours that the personal care attendants are present.

The ADA Ruling

Rodriguez was decided soon after the United States held in *Olmstead* that unjustified institutionalization is a form of discrimination under the Americans with Disabilities Act of 1990 (ADA),[9] including its provision that a state's services must be provided in the "most integrated setting appropriate" to the individual's needs. Applying an analysis similar to that used in other discrimination statutes, *Olmstead* held that the ADA requires states to provide supportive services for persons with disabilities so that they can live in their communities rather than in nursing homes, unless such services would impose an undue burden on the State and would require a substantial or fundamental alteration of the State's program. The Court listed certain general factors that would be considered in determining whether provision of community services would impose an "undue burden" on a State, but did not draw a bright line, leaving this issue to be developed in future litigation. Significantly, the Court allowed States to have waiting lists for community-based services, but required that the lists move at a reasonable pace.

The Second Circuit found that the disparate treatment of cognitively impaired persons compared to physically disabled persons was not discrimination, even though the Supreme Court in *Olmstead* specifically found the ADA to apply to discrimina-

tion among groups of disabled individuals.[10] In reaching its conclusion, the Second Circuit fell into a common semantic trap wisely anticipated by the Supreme Court in an earlier decision, *Alexander v. Choate*.[11] The Court there warned that, "'Anti-discrimination legislation can obviously be emptied of meaning if every discriminatory policy is 'collapsed' into one's definition of what is the relevant benefit.'"[12] That is exactly what happened in *Rodriguez*, where New York was allowed to invent its own definition of the relevant benefit—personal care—as care that is solely physical assistance. With the relevant benefit so defined, people with cognitive impairments can never complain that they are being denied "personal care," since what they need is verbal rather than physical assistance. By characterizing the non-physical care needed by the cognitively impaired as a so-called "separate service" of "safety monitoring" (even though it is provided by the very same aides who provide physical care), the Court allowed New York to deny those with cognitive impairments access to the same benefit available to those with physical impairments—personal care services in amounts up to 24 hours a day to maintain them safely at home. By this reasoning, *Rodriguez* never reached the "undue burden" analysis at all.

Second, *Rodriguez* incorrectly found the *Olmstead* decision of the Supreme Court—and the entire integration mandate of the ADA—inapposite. Quoting *Olmstead* as requiring only that states not discriminate "'with regard to the services they in fact provide,'" the Second Circuit concluded that since New York provided safety monitoring to no one, it could not be discriminating by not providing it to the plaintiffs. Under this reasoning, a state that refused to treat anyone with a mental illness in the community, but rather required even the most minor care to be provided in an institution following a commitment proceeding, would not be violating the integration mandate of the ADA because it provided "community mental health services" to no one. This reasoning eviscerates the ADA, and poses an enormous threat to persons with disabilities nationwide as they advocate for their states to implement the integration mandate upheld by *Olmstead*.

What the Second Circuit failed to take into consideration is the admitted fact that New York *does* pay for safety monitoring provided to a person with a cognitive disability *who is put in a nursing home*. Indeed, when some of the *Rodriguez* plaintiffs are no longer able to cope in the community because they have been denied personal care services, they will enter nursing homes explicitly to receive those services. So, it is not the case that New York does not pay for the personal care needed by the cognitively impaired. It is merely the case that in order to receive such care, a person must be willing to live in an institution, here, a nursing home. This is exactly the type of unnecessary segregation of the disabled that the ADA is intended to address, and that the *Olmstead* court declared to be a form of prohibited discrimination.

The Medicaid "Amount, Duration and Scope" Regulation

Rodriguez grossly distorts the longstanding federal Medicaid regulation that requires that, in every state's Medicaid program, "[e]ach service must be sufficient in amount, duration or scope to reasonably achieve *its* purpose."[13] Before *Rodriguez*, many courts as well as HCFA properly interpreted this regulation to mean that the scope of a particular medical service provided by a state must be sufficient to reasonably achieve the purpose of the applicable federal *category* of services, such as the *categories* of prescription drugs or physician's services, or, as in this case, the *category* of personal care services. This interpretation held states to a critical minimum standard of quality health care. Departing from that precedent, *Rodriguez* holds that a court need not examine the purpose of the benefit *category*.

Applying that interpretation of the federal regulation to personal care, *Rodriguez* refused to consider whether New York's refusal to provide "safety monitoring" for people with Alzheimer's disease rendered the state's personal care benefit insufficient to reasonably achieve the purpose of personal care services, which is unquestionably to enable elderly and disabled recipients to remain safely in their homes. The Court held that the State need only meet the purpose of a particular service or treatment within a category, no matter how narrowly and arbitrarily that service or treatment—and its purpose—is defined by the State. Here, New York defined its personal care service as hands-on physical care. Having allowed the state to employ that self-serving definition, the Second Circuit then had no difficulty finding that the refusal to provide verbal supervision for persons with cognitive impairments did not defeat the service's purpose.

Rodriguez's Medicaid ruling has serious repercussions for all Medicaid services. This key federal regulation may no longer stand as a bar to cutbacks by New York and other states in the amount or scope of Medicaid services, whether prescription drugs, home care, or physician's services.

Advocacy after *Rodriguez*—Legislation and Public Education

Since *Rodriguez* sharply limits the legal grounds for challenging cuts in Medicaid home care services, advocates must explore possibilities in legislative action and public education to restore adequate home care. The cuts challenged in *Rodriguez* affect not only people with Alzheimer's disease but others who do not receive adequate amounts of home care because of "task based assessment," which is the method for assessing the need for home care challenged in *Rodriguez*. If the inhumanity of these cuts can be publicized, reforms are possible even without victories in court.

In the 2001 legislative session, the NYSBA Elder Law Section and other organizations will again support passage of Assembly Bill A.10424, proposed in the 2000 session by Assemblywoman Helene Weinstein. This bill would amend the Social Services Law to define personal care services so as to include "safety monitoring." Other legislative action should include repeal of the cost-saving targets, which require that New York City—and a few other districts with high home care costs—slash a specified dollar amount from their home care expenditures or face stiff fiscal penalties. It is these targets that, at least in part, motivated New York to impose "task-based assessment" and to eliminate safety monitoring.

On a national level, advocates have pressed the United States Health Care Financing Administration (HCFA) to correct, through a letter addressed to all State Medicaid Directors, the clear errors in the *Rodriguez* decision regarding both the ADA and the federal "amount duration and scope" regulation. By the time this article is printed, we hope that HCFA will have issued a directive under the Clinton Administration. If not, the possibility of securing such a directive seems slight under the Bush administration. Given the binding effect of *Rodriguez* in the Second Circuit, however, even a strong directive from HCFA may not undo the harm in New York.

On an individual client level, one can still advocate for adequate home care since New York's statute and regulations still authorize up to 24-hour care per day. Since "safety monitoring" is no longer recognized as warranting home care, treating physicians and advocates should describe their clients' needs more specifically in terms of assistance with the activities of daily living (ADLs). Most "safety monitoring" is, in fact, assistance with activities such as safe ambulation and transfer.

Endnotes

1. Nearly one-third of total federal Medicaid expenditures ($51.3 of $154 billion in 1996) were spent on long-term care. AARP Public Policy Inst., *Across the States 1998: Profiles of Long-term Care Systems* 143 (1998). The same proportion of New York State's Medicaid expenditures are for long-term care. *See* n.3.
2. *Id.*
3. N.Y.S. Dep't of Health Office of Medicaid Management, On-Line SURS Information Retrieval System, *Medicaid Reference Statistics Federal Fiscal Years 1996-1998* (January 2000) (figure for fiscal year 1998 includes nursing homes and intermediate care facilities for the developmentally disabled).
4. *Id.*
5. 527 U.S. 581 (1999).
6. 197 F.3d 611 (2d Cir. 1999), *cert. den'd, (*October 2000).
7. "Personal care" services—known as "home attendant" services in New York City—are authorized under N.Y. Social Services Law § 365-a(2)(e). The other home care programs are "home health services," which include visiting nurse, home health aide, and physical therapy, Soc. Serv. L. § 365-a(2)(d); Long Term Home Health Care Programs (LTHHCP) or "Lombardi;" Soc. Serv. L. §§ 367-c, 366(6); and Private Duty Nursing Services, Soc. Serv. Law § 365-a(2)(l).
8. 18 N.Y.C.R.R. § 505.14.
9. 42 U.S.C. §§ 12101 *et seq.*
10. 527 U.S. 581, 598 at n.10 (1999).
11. 469 U.S. 287 (1985).
12. 469 U.S. at 301 n.21.
13. 42 C.F.R. § 440.230(b) (emphasis added).

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Grandparent Rights News

The Legal Authority of Grandparent Caregivers Who Are Not Legal Custodians or Guardians

By Gerard Wallace

Grandparents and other relatives often do not seek legal custody or guardianship of the children in their care because they fear that court involvement may jeopardize their informal custody or upset fragile family relationships. These relatives may be caring for children because of family discord caused by a parent's drug-related problems, mental or physical illness or incarceration, or for less dramatic reasons, such as the need for a parent to work the night shift or at a location too far away from home for commuting. In all these situations, the lack of a court-ordered guardianship or custody should not inhibit relatives from properly caring for children. Unfortunately, however, these informal caregivers find that they do not have the legal authority to make necessary decisions regarding schooling and medical care.

The legal authority in New York for decisionmaking for minors, including medical and school decisions, rests upon various statutes that limit responsibility to either parents and guardians[1] or permit a "person in parental relationship" to assume a limited degree of responsibility. Both the New York Education and Health Laws limit decisionmaking to parents or "persons in parental relationship." "Persons in parental relationship" are defined in these laws as parents, court appointed guardians, and "custodians."[2] "Custodians" are further defined as anyone caring for a child because the parents have died, are incarcerated, are mentally ill, have abandoned the child, are living outside the state or whose whereabouts are unknown. The definition does not include legal custodians who are persons who have court-awarded physical custody of children and responsibility for their care.[3]

School Decisions

Only certain responsibilities regarding schooling can be exercised by "persons in parental relation." Caregivers who meet this definition are responsible for general school activities and may participate in parent/teacher associations. But many important powers are exclusively retained by the absent parent.[4] Of note, a child's residence in the home of a "person in parental relationship," does not automatically entitle that child to free tuition at a public school in the district where the caregiver resides. Entitlement depends on proof of the child's permanent residency in a school district.[5]

The list of circumstances that qualify informal caregivers as "persons in parental relationship" clearly leaves out many relative caregivers who have been informally requested by the child's parents to provide care, or who have the child's parents and the child living with them, or who are caring for a child whose parents live nearby in the community. These caregivers depend on local school officials to overlook the law and accept their authority. Because acceptance of their authority is arbitrary, informal caregivers may, at any time, find themselves denied access to school records or membership in a parent/teacher association, or even unable to find out if a child in their care is attending classes on a particular day.

Medical Decisions

Similar limitations apply to medical decisionmaking. Here, however, the authority granted by statute to "persons in parental relationship" does not approach the scope allowed by the Education Law. "Persons in a parental relationship" can only consent to immunizations, not to general medical care.[6] Here too, enforcement is arbitrary, left up to local medical providers who may or may not decide to accept an informal caregiver's taking charge of a child's medical care.

Delegation of Authority

Parents cannot legally transfer any of their own authority, nor can they delegate or share it with relatives.[7] New York's general power of attorney law does not mention the delegation of parental authority for schooling or medical decisions.[8] Parents can only consent to the transfer of medical authority in a judicial guardianship proceeding. Legal custody proceedings, which are usually assumed to have similar effects as legal guardianship, do not have firm statutory footing for granting the authority to take charge of a child's schooling or medical care, unless a legal custodian inadvertently happens to qualify as a "person in parental relationship." Nevertheless, school

officials and medical providers almost always agree to accept the authority of legal custodians.

In many states, these barriers to informal care do not exist. Parents can authorize informal caregivers to make these decisions by a notarized designation signed by the parent (although in some states only certain relatives can be designated).[9] In 1998, a Bill that would have granted parents this authority passed both houses of the New York State legislature, but was vetoed by Governor Pataki.[10] Enactment of designation authority, if accompanied by amendments to the definitions of "persons in parental relationship" would place parents in a stronger position to control the care of their children and alleviate the under-inclusiveness of the current narrow definitions, including the current failure to include legal custodians.

Sharing of Authority

Unfortunately, another fairly common situation has not been addressed in recently proposed bills. When a parent and grandparent wish to share responsibility for a child's schooling and/or medical care, no mechanism for joint legal recognition currently exists. The present legal requirement that authority must be transferred, not shared, ignores the existence of intergenerational families. Enabling parents to authorize the sharing of their authority with all non-relatives who are co-parenting may not be feasible until some time in the future, but consideration of the unique relationship between grandchildren and grandparents, who are the natural substitute caregivers for their grandchildren, should lead to legislative approval of shared responsibility for schooling and medical decisions between grandparents and consenting parents.[11]

What is clear about the task faced by informal caregivers is that what should be simple is too complex, and that the laws are unevenly applied. The poor match between statutes and the reality of intergenerational families places unnecessary legal barriers upon grandparents and other informal caregivers who are trying to help children.

Endnotes

1. N.Y. Al. Bev. Law § 65-c (2)(b) (only a parent or guardian can give alcoholic beverages to a person under the age of 21); N.Y. Al. Bev. Law § 99-f (only a parent(s) or lawful guardian(s) can petition the liquor authority to obtain a special permit allowing any person under the age of 18 to perform as an entertainer in an establishment licensed to sell alcoholic beverages); N.Y. Civ. R. Law § 509 (only a parent or guardian can provide written consent for the use of a minor's portrait or picture for advertising purposes); N.Y. Dom. Rel. Law § 15 (only a parent or guardian may consent to the marriage of a minor, unless to the minor's knowledge neither parent nor guardian is living, then the written consent of the "person under whose care or government the minor or minors may be before a license shall be issued"); N.Y. Ment. Hyg. Law § 9.90 (only a parent or guardian or the mental hygiene legal service may consent to the transfer of a mentally ill minor); N.Y. Pub. Health Law § 1399-ff (only a parent or guardian can make a complaint regarding sale of tobacco products to their child); N.Y. Soc. Serv. Law § 384 (1)(d) (adoption); N.Y. Veh. & Tr. Law § 2410 (only a parent or guardian can allow an unattended child under 16 to operate an ATV upon their property); N.Y. Ins. Law § 321(c) (only a parent or guardian can consent to release of medical information.); N.Y. Pub. Health Law § 2442 (only a parent or guardian or a "person legally empowered to act on behalf of the human subject" may consent in writing to human research upon a minor); N.Y. Pub. Health Law § 2961(18) and § 2967 (only a parent [who has custody of the minor] or a legal guardian can consent to orders not to resuscitate). N.Y. Gen. Oblg. Law § 3-112 (only a parent, guardian, local social services department, or foster parent is liable for property damages caused by a minor).
2. N.Y. Educ. Law § 3212(1) & N.Y. Public Health Law § 2164. *See also* N.Y. Educ. Law § 4111 (Indian child truant returned to person in parental relation; schooling record, issuance, person in parental relation); N.Y. Educ. Law § 3222 (school records); N.Y. Educ. Law § 4402 (Committee on Special Education can deal with person in parental relationship); N.Y. Educ. Law § 4107 (person in parental relation to an Indian child can be held criminally responsible for attendance), N.Y. Educ. Law § 4106 (duties of person in parental relation to Indian children). *See also* Individual Education Plans (IEPs), 34 U.S.C. §. 300.20(a).
3. Despite the absence of statutory authority, non-parent legal custodians usually do not encounter difficulties exercising decisionmaking authority for minors in their custody.
4. Parents and guardians retain exclusive powers for some school situations. only parents and guardians can consent to school drug testing, N.Y. Educ. Law § 912-a; receive tuition reimbursement, N.Y. Educ. Law § 562; consent for employment certificate, N.Y. Educ. Law § 3217, N.Y Educ. Law § 2119 and farm work permits, N.Y Educ. Law § 3226; and in attendance conflicts with religion of parent or guardian, can be absent from education, N.Y Educ. Law § 3204.
5. N.Y. Educ. Law § 3202.
6. N.Y. Public Health Law § 2164.
7. Regulation of the Chancellor No. A-660, issued June 14, 1999, at pp. 11-13, permits parents of New York City children to designate certain limited schooling responsibilities to another individual. The designation is termed a transfer, not a delegation.
8. N.Y. Gen. Oblig. Law § 5-1502I, "Personal Relationships and Affairs," provides that the agent may be appointed "to do any other act or acts, which the principal can do through an agency, for the welfare of the spouse, children, or dependents of the principal or for the preservation and maintenance of the other personal relationships of the principal to parents, relatives, friends and organizations." While it can be argued that this authority includes education and medical, in practice it has been used exclusively for financial needs. This subdivision specifically refers to real and personal property. N.Y. Gen. Oblig. Law § 5-1502I(14).
9. Approximately 20 states have adopted the Uniform Probate Codes delegation of parental authority. UPC § 5-102. A number of other states have similar laws.
10. Veto Memorandum #1388 listed a number of concerns: the Bill did not specifically authorize a caregiver to be responsible for a child's absence from school; the suggested statutory form may preempt less formal types of authorizations; medical decisionmaking can only be granted by a court; two parents could disagree regarding the authorization of a caregiver; and the Bill did not address proof of residency with a

caregiver. Many of the governor's objections are addressed in this year's amended bill. S.4000/A7052 will be reintroduced in January 2001. The new bill number is not yet available.

11. While not commonly ordered, joint custody may be another means for shared parenting.

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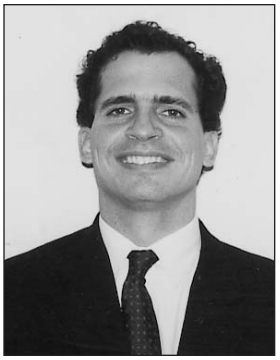
Bonus News

Navigating Through the Spousal Refusal Lawsuit

By Matt Nolfo

I. Introduction



One of the most important challenges that our elderly clients are currently facing is the threat of a spousal lawsuit. Local departments of social services are increasingly pursuing claims for reimbursement against spouses for either nursing home or home care Medicaid paid on behalf of an ill spouse where the spouse had executed a spousal refusal as part of the Medicaid application process. New York City's Human Resources Administration (HRA) has been particularly aggressive in pursuing these claims. More importantly, HRA is randomly pursuing all types of refusing spouses with income and/or resources barely above the allowable levels to refusing spouses who have significant assets and/or income. Moreover, the age and health of several of the refusing spouses renders it difficult for them to pay over a lump sum of their savings which may be needed to pay for their own health care costs and living expenses or those of dependent family members.

This crisis has recently received the public attention that it deserves. The New York City Public Advocate's office has recently requested that HRA impose a moratorium over these cases until the City can fairly evaluate whether there exists a true public purpose to pursue these claims. In addition, on October 17, 2000, the current Chair of the Elder Law Section, Bernard A. Krooks, Esq. along with several other elder law professionals and refusing spouses who are being sued by HRA testified persuasively before the New York City Council's Government Affair Committee in the attempt to compel the Council to take action against the pursuit of these claims by HRA. In addition, the Association of the Bar of the City of New York has distributed questionnaires to several members of the elder law community to ascertain a clear picture of the types of cases that HRA is pursuing so that the City Bar may also take a role in attempting to either preclude or modify HRA's pursuit of these claims.

Finally, while my experience with spousal lawsuits is limited to New York City, I have been advised that other counties throughout New York State have begun pursuing reimbursement against refusing spouses. However, I am also advised that counties outside of New York City are only pursuing reimbursement from refusing spouses if their resource levels are significantly higher than the maximum Community Spouse Resource Allowance (CSRA) of $87,000 and/or Minimum Monthly Maintenance Needs Allowance (MMMNA) of $2,175, which is clearly not the case in New York City.

This article will attempt to provide an overview of spousal lawsuits and will recommend various steps that should be taken by advocates that may help to achieve the best possible results in defending the interests of refusing spouses in these actions.

II. Basis of the Spousal Refusal Lawsuit

As you know, with regard to nursing home Medicaid, the regulations provide that the refusing spouse is entitled to retain assets in a certain amount determined as follows: If the total non-exempt resources are $149,640 or less, then the CSRA is $74,820. If the couple's resources are between $149,640–$168,240, the CSRA is one-half the value of the non-exempt assets. If the couple's resources exceed $168,240 then the CSRA is $87,000. To the extent that the community spouse's monthly income (including the Spousal Enrichment) is still less than the MMMNA of $2,175, the community spouse is entitled to retain resources above the CSRA ("enhanced CSRA") as necessary to generate sufficient income to raise the community spouse to the MMMNA of $2,175. Of course, if the ill spouse is applying for Medicaid home care, then the refusing spouse may only retain $3,750 in non-exempt resources and $625 in monthly income.

To the extent that the refusing spouse possesses resources in excess of the applicable CSRA and/or MMMNA, the legal theory upon which the ill spouse should be eligible to receive Medicaid benefits is based upon the well spouse's refusal to make his or her income and resources available for the cost of the ill spouse's long-term care (also known as "spousal refusal"). As part of the spousal refusal equation, the ill spouse must execute an assignment of support on behalf of Medicaid, granting Medicaid the right to pursue all claims against the refusing spouse for benefits paid on behalf of the ill spouse. If Medicaid is approved for the ill spouse, the refusing spouse may be sued by the local department of social services, upon the theory that the refusing spouse is deemed to have "sufficient ability" to pay some portion of the cost of the ill spouse's care. If Medicaid is successful in arguing its position in your case, the refusing spouse would be responsible for reimbursing Medic-

aid for the amount of Medicaid benefits paid on behalf of the ill spouse and for the ongoing costs of maintaining ill spouse in a nursing home or in a home care setting.

III. Authority to Support Spousal Lawsuit

The authority upon which Medicaid predicates its authority to commence spousal lawsuits is found at Social Services Law § 101 and § 366(3)(a). Section 101, in pertinent part, provides:

> Except as otherwise provided by law, the spouse or parent of a recipient of public assistance or care or of a person liable to become in need thereof shall, if of sufficient ability, be responsible for the support of such person, provided that a parent shall be responsible only for the support of a child under the age of twenty-one years.

In addition, § 366(3)(a) provides that:

> Medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by the regulations of the department, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative or the refusal or failure of such relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three and other applicable provisions of law.

The statute essentially provides that a refusing spouse of sufficient ability, that being a refusing spouse with resources and/or income above the allowable Medicaid levels, is legally responsible for the support of his or her spouse. And while the execution and filing of a spousal refusal will not prevent the ill spouse from qualifying for Medicaid, Medicaid has the right to recover all monies paid on behalf of the ill spouse from the responsible relative, the refusing spouse. Thus, with regard to nursing home Medicaid, pursuant to Social Services Law § 366-c(2)(d)(i), any non-exempt resources held by the refusing spouse exceeding a maximum of $87,000 are deemed available to pay for the cost of the institutional spouse's care. Similarly, pursuant to Social Services Law § 366-c(2)(g) and (h), any monthly income of the refusing spouse that exceeds $2,175 also must be made available for the cost of the ill spouse's care. Once again, the levels for Medicaid home care are only $3,750 in resources and $625 in income.[1]

A reading of the two foregoing statutes does reveal an inconsistency. Under § 101, the refusing spouse must be "of sufficient ability" to pay only, which indicates that in the event that the refusing spouse *either* has resources *or* income above the allowed levels, then Medicaid has the right to sue. Conversely, under § 366(3)(a), the statute mandates that the refusing spouse must have *both* resources *and* income above the allowed levels for Medicaid to assert a right to sue. Medicaid obviously relies on the lesser standard set forth under § 101. While we have challenged the sufficiency of demand letters on this ground, no ruling has yet been made in this issue.

IV. Demand Letter

Prior to the commencement of a spousal lawsuit, Medicaid will routinely serve a demand letter on the refusing spouse seeking reimbursement for the Medicaid benefits that have been paid on behalf of the ill spouse for services rendered either in a nursing home or at home.

The demand letter will set forth the amount of money that Medicaid has paid on behalf of the ill spouse, the time period for which benefits have been paid and requests that the refusing spouse either reimburse Medicaid for the monies paid by Medicaid on behalf of the ill spouse or Medicaid will commence a lawsuit to recover such monies. Typically, Medicaid will allow for 15 days for the refusing spouse to remit such monies. The demand letter will also state the amount of resources and income that the refusing spouse has in excess of the allowable resource and/or income levels. Please note that Medicaid may only seek reimbursement for an amount the exceeds the resource level, even if Medicaid has actually paid out a greater amount (if a community spouse has $20,000 over the CSRA, and Medicaid has paid out $100,000, Medicaid may only seek reimbursement up to $20,000).

You should keep in mind that the service of the demand letter upon the refusing spouse does not signify the commencement of a lawsuit. Rather, the demand letter is meant to provide the refusing spouse an opportunity to avoid litigation by either paying the amount requested or challenging same and attempting to negotiate a settlement.

V. Advocate's Role at the Demand Letter Stage

The first thing that an advocate should do on behalf of the refusing spouse is to verify the accuracy of the demand letter. The advocate should verify that the time period during which Medicaid is claiming that benefits were paid that is set forth in the demand letter is correct. Many times it is difficult for a refusing spouse to actually determine this. As a result, we have contacted Medicaid's legal department and requested a copy of a CDR, which is a breakdown of payments made by Medicaid on behalf of the ill spouse on a monthly basis. The CDR gives the refusing spouse a meaningful opportunity to verify whether the amount set forth in the demand letter is accurate.

Second, the practitioner should be made aware that Medicaid will sue for a period certain. This is not problematic if Medicaid sues for the period covering the time that benefits commenced through the death of the ill spouse. However, if the ill spouse is still alive and receiving benefits, then Medicaid will take the position that it is only authorized to sue for the retroactive period certain and will not address Medicaid benefits that are being paid prospectively. While we have even provided consent for Medicaid to amend its complaint for the inclusion of ongoing Medicaid benefits to achieve a more global resolution, Medicaid has declined to agree to do this. As a result, the refusing spouse is under the threat of an additional lawsuit for continuing benefits even if the initial lawsuit is resolved.

The refusing spouse should also verify that the amount of resources and/or income that Medicaid claims are in excess of the allowable resource and/or income levels are accurate to determine if the refusing spouse has "sufficient ability" to pay toward the cost of the ill spouse's care. For example, Medicaid will simply set forth the excess amounts that existed at the time that eligibility was determined on behalf of the ill spouse. However, Medicaid benefits may have been paid for a significant period of time during which the refusing spouse's resources and income levels may have been altered and were no longer in excess of the allowable levels. As a result, it may make sense to advise Medicaid that their allegations regarding resources or income levels are not correct and that at some point the refusing spouse no longer had the "sufficient ability" to pay as the statute requires. While it was believed that this will serve little purpose at the initial stage of litigation, the First Department in *The Commissioner of the Department of Social Services v. Fishman*[2] suggests that challenging the amounts of resources and income set forth in the demand letter may be advantageous.

Finally, it will be important to ascertain from the refusing spouse whether the service of the demand letter is the first request that Medicaid has made for reimbursement for payments made on behalf of the ill spouse. If this is the case, and if Medicaid has waited a significant period of time to make the request during which the benefits have been paid, then this lack of notice should support a laches defense that is discussed in greater detail below.

Please note that there is nothing in the Social Services Law that requires that the demand letter be a prerequisite to commencing a lawsuit against the refusing spouse. This is so even though each complaint that Medicaid has served in these cases invariably recites that a demand letter has been served on the refusing spouse to no avail. The stated purpose of serving the refusing spouse with a demand letter is to afford the refusing spouse the opportunity to avoid litigation and to pay off or dispute the amounts which Medicaid claims it has paid on behalf of the ill spouse. As a result, the amount sued for in the summons and complaint should be the same amount that is set forth in the demand letter. However, it has been our experience that on various occasions the summons and complaint will not be served for several months after the demand letter was served. In the interim, if the ill spouse is still alive and receiving benefits, the summons and complaint will request reimbursement fro Medicaid benefits paid for a longer period and thus a greater amount of money than is set forth in the demand letter. This seems unfair since the refusing spouse has been led to believe that if the sum certain in the demand letter is paid, then no lawsuit will follow. As such, the demand letter does not then really provide the refusing spouse the opportunity to avoid litigation as it states it does. While we have attempted to argue that this inconsistency between the demand letter and the summons and complaint should render the complaint defective, no ruling has been made on that argument.

VI. Settling a Spousal Refusal Case After Denial Letter But Before the Commencement of a Lawsuit

In the past, Medicaid allowed a significant time period to elapse between the time the demand letter was served and a spousal lawsuit was commenced by the service of a summons and complaint. This is no longer true. In fact, in some cases, if the demand letter is not responded to within a 15-day period, Medicaid will automatically serve a summons and complaint to initiate a court proceeding against the refusing spouse shortly thereafter. As such, it is imperative that an advocate contact Medicaid's legal department at the earliest possible time once a demand letter has been received by the refusing spouse.

The demand letter gives you an opportunity to explore the possibilities of settlement with Medicaid before the commencement of a lawsuit against your client. In many cases, Medicaid is flexible enough to allow you a month or two to get to know the facts of the case before making a settlement offer. However, at the same time, Medicaid is invariably more rigid with its settlement possibilities prior to the commencement of the lawsuit. At the very least, it is a good opportunity to advise Medicaid that the client will be represented by legal counsel and that it will require more resources and effort on Medicaid's part to secure the type of result that it would normally be able to gain if the refusing spouse was without legal counsel.

VII. The Service of a Summons and Complaint—The Actual Commencement of the Lawsuit

Ordinarily, if the refusing spouse has not contacted you upon receiving the demand letter, he or she will seek your assistance upon being served with a summons and complaint. Hopefully, the client will have contacted you immediately after being served so that the time period to respond to the summons and complaint has not expired.

CPLR 308 governs the methods of service of the summons and complaint. CPLR 308(1) deals with service on the person of a defendant. If your client is personally served with the summons and complaint, then he or she has 20 days to respond. CPLR 308(2) allows for the service of a summons and complaint upon a person of suitable age and discretion. In this instance, the refusing spouse has 30 days to respond. Medicaid is also required to serve an additional copy by regular mail within 20 days of leaving a copy with a person of suitable age and discretion. CPLR 308(4) provides for service by affixing a copy of a summons and complaint at a defendant's residence or actual place of business and mailing another copy of the summons and complaint by regular mail after having exercised "due diligence" in attempting to personally serve the defendant. This type of service is commonly referred to as "nail and mail." It has been our experience that the majority of refusing spouses that we are currently defending have been served by nail and mail service.

VIII. The Answer Itself

As some of you may know, the authority for commencing actions against refusing spouses is based in statute only. As the language under SSL §§ 101 and 366(3)(a) as set forth above demonstrates, Medicaid's right to seek reimbursement is clear. As a result, substantively, a refusing spouse may have difficulty asserting meaningful affirmative defenses and counterclaims depending on the circumstances of each case.

As such, because a defendant refusing spouse has limited ability to exploit the substantive issues of the lawsuit, a greater focus on the procedural elements of the case is necessary. This is an important step to achieve in order to frustrate Medicaid's attempts to maximize the amount of reimbursement that it is seeking from the defendant refusing spouse.

IX. Procedural Considerations

1. Personal Jurisdiction

The first question that you should ask your client upon being advised of the fact that they were served with a summons and complaint is how and when they were served. Normally, actual personal service or substituted service are rarely achieved and generally the custom of service is by conspicuous place service and mailing ("nail and mail") under CPLR 308(4). As such, in cases where personal and/or substituted service were attempted but were unsuccessful, you should make sure the client found the summons and complaint affixed to the door of his or her residence or actual place of business. You should also ask the client whether he or she has received a copy of the summons and complaint by mail. The client should bring the copies that he or she received to you for your examination. Regardless of the manner in which your client was served, it is important to request either on your own or through a lawyers' service a copy of the affidavit of service that was filed at the County Clerk's office to see if the manner of service set forth in the Process Server's affidavit is consistent with the service that is explained to you by the client. Often, there are inconsistencies which should prompt a motion to dismiss on that ground alone. Even if there is a slight doubt that service was not rendered adequately under CPLR 308, then there is no question that your first affirmative defense should be that service was not properly made. This is a stumbling block for Medicaid because it requires a traverse hearing on the issue of service and will make Medicaid more amenable to settle the case. We believe that we have achieved more favorable settlements under the threat of a traverse hearing. In addition, it has been our experience that the process servers who work for Medicaid commonly make services in violation of the provisions under CPLR 308.

2. Verification

Because the complaints are verified by a staff attorney at Medicaid as is allowed by CPLR 3020(d)(2), the answer that is made in response to the complaint must also be verified pursuant to CPLR

3020(a). As such, this means that you must draft an answer with affirmative defenses and/or counterclaims and go over it with your client to make sure that it is satisfactory in a relatively short period of time or risk default. Many times the clients are not able to review the answer with you in person which causes an additional delay in your ability to serve the answer on a timely basis. As a result, it is best to sometimes serve a simple notice of appearance with a general denial of the allegations set forth in the summons and complaint. CPLR 3025(a) allows a refusing spouse as a defendant in a lawsuit 20 days to amend the answer that was served as a matter of right without permission from the court. This provision is important to understand and to take advantage of in these types of proceedings.

You can also request time from Medicaid to interpose an answer. They are normally open to extending your time to answer for at least a few weeks if you will be unable to respond on a timely basis depending on when the client first requested your assistance.

3. Pleading Defect

You must review the complaint carefully and the pleadings set forth therein. Inconsistencies among the amount of money requested, the time periods for which service was requested, allegations that the refusing spouse had either resources and/or income above the resource and income standards that are allowable for refusing spouse are all pre-requisite factors that must be properly pled. If this is not the case, then you should argue that the complaint fails to set forth a cause of action and the complaint should be dismissed under CPLR 3211(a)(7).[3] In *Fishman*, Medicaid's failure to plead that the refusing spouse retained resources and/or income for the entire time that Medicaid benefits were paid on behalf of the ill spouse and not just at the time that eligibility was established was defective and resulted in the dismissal of the complaint. However, the *Fishman* case was recently reviewed by the Appellate Division, First Department and reversed. The First Department held that Medicaid did not have to plead that the refusing spouse had resources and/or income in excess of the allowable Medicaid amounts for the entire time period that benefits were paid. Instead, the First Department reasoned that upon executing the spousal refusal, the refusing spouse created an implied contract to pay on behalf of the ill spouse and ruled that Medicaid should not have to make "continual reassessments of the responsible(refusing) spouse's ability to pay." The First Department went on to rule that "DSS's right to recover accrued and the implied contract with defendant (refusing spouse) was created when she refused to make her income available for her husband's support, at the approximate time that DSS examined her income and resources and found that she was sufficiently able to pay for her husband's care."

The First Department's ruling in *Fishman* eases Medicaid's pleading requirements to the extent that it does not require Medicaid to allege the amount of resources and for income held by the refusing spouse throughout the entire time that benefits were paid. However, Medicaid must still plead the correct amount of benefits spent, the correct time period for which Medicaid was paid, the applicable resource and income standards and plead that the refusing spouse had sufficient ability to pay for the ill spouse's care, even if only at the time eligibility was determined. Furthermore, in the event of trial or a motion for summary judgment, the Court should require that Medicaid prove that the refusing spouse was of "sufficient ability" for the time period for which Medicaid is seeking reimbursement. *Fishman* addresses a pleading requirement for Medicaid to demonstrate a cause of action only. It should not diminish Medicaid's burden of proof at trial.

Finally, the result in *Fishman* does not make sense since the refusing spouse's obligation to pay for the ill spouse's care is prompted by the refusing spouse having resources or income levels above the allowable Medicaid amounts. The First Department is not fairly contemplating that the amounts of resource and income could decrease from the date of eligibility which is sometimes the case with elderly refusing spouses who have increasing medical expenses of their own. As such, the refusing spouse's "sufficient ability" to pay may be significantly altered and their degree of liability under the foregoing statute modified.

4. Laches Defense

You should also measure how long Medicaid has been providing Medicaid payments to the nursing home or to the home care agency and what time period has elapsed from the time that payments had begun and that Medicaid sent the demand letter requesting reimbursement from the refusing spouse. Often, the time period is within a one to two year period. As such, it is arguable that a defense of laches will preclude the request in the complaint by Medicaid for all monies to be paid and/or partially preclude Medicaid from collecting that money. The defense of laches essentially provides that Medicaid's neglect to notify the refusing spouse of its intent to seek reimbursement in a timely fashion results in a significant amount of benefits paid on behalf of the ill spouse. In many cases, this will prejudice the refusing spouse's ability to pay these significant amounts of money that Medicaid has allowed to accumulate without furnishing notice to the refusing spouse. Had

Medicaid made the claim at least in the time shortly after payment of Medicaid benefits commenced, then it is more likely that the refusing spouse would be better able to pay the Medicaid claim in a lump sum form.

The defense of laches must be reconciled with Medicaid's ability to seek reimbursement on benefits paid during the past ten years. Social Services Law § 104(1). Our view is that SSL § 104(1) operates as a statutes of limitations during which time Medicaid has the right to sue. However, we still believe that Medicaid's claim should be subject to defenses such as laches. For example, in a contract dispute, although a complaining party has six years to file a claim of breach, laches defenses, if appropriate, are valid and binding. Where appropriate, a defense of laches should have the same effect in a spousal lawsuit.

X. Pre-Trial Discovery

Because the scope of the issues involved in these matters are fairly limited, if the client has resources to fund it, seeking discovery on behalf of the defendant would be helpful. Pursuant to CPLR 3101, discovery may be sought in any civil court proceeding as long as the information sought is "material and necessary" to the case. In several instances, we have served requests for document production, written interrogatories and requests for oral depositions upon Medicaid to force Medicaid to produce evidence to corroborate the allegations made in the complaint that supports the spousal proceeding. Discovery can be advantageous to the extent that it makes an impression upon Medicaid that as legal representative of the refusing spouse, you are serious about fighting its claim and not allowing them to secure a favorable settlement easily. You may also be able to reveal defects in Medicaid's case that may result in dismissal or yield a more favorable settlement.

XI. Pre-Trial Conference

Many times, a dispute of the rights of the parties in the discovery process necessitates a pre-trial conference in State Supreme Court which is often an excellent opportunity to expose the unfairness of many of the spousal cases. As I am sure most of you know, a pre-trial conference in Supreme Court serves as a vehicle for the Court to resolve any outstanding discovery issues, to encourage settlement, and, if necessary, to push the matter toward trial. Our experience has been positive at this level. Many times, the judges and their law secretaries are not aware of Medicaid's ability to seek reimbursement from refusing spouses. In cases where the facts are often favorable to the refusing spouse, due to the declining benefits, diminished resources and income as well as the several other factors, the courts' reactions have generally been sympathetic and settlement discussions are many times thereafter more favorable to the interests of the refusing spouse.

XII. Beyond Discovery

There has never been a trial in any spousal lawsuit in New York City. While several attorneys feel that Medicaid would have an easy case, your author does not share that opinion. In the event that the refusing spouse does not sign the Medicaid application on behalf of the ill spouse, then Medicaid would have to prove that the refusing spouse had and continued to have all the resources and/or income above the income and/or resource allowance for the time that they are suing for. In the evidentiary sense, this may not be easy. It is likely that Medicaid would have to call witnesses from all of the financial institutions to prove the amount of the refusing spouse's resources and/or income to prove "sufficient ability." This could be an expensive and time consuming task for Medicaid to undertake.

Medicaid (HRA) has also made six summary judgment motions against refusing spouses pursuant to CPLR 3212. Four of these motions were settled, the fifth motion for summary judgment was dismissed without prejudice and the sixth is pending. However, as most of you know, these motions can be denied if an affidavit in opposition is filed by the refusing spouse raising factual disputes on the allegations made in the summary judgment motion.

XIII. General Conclusions

Most of these spousal lawsuits settle. However, few settle until the lawsuit is commenced and the case has been pending for at least six months to a year.

At this time, Medicaid is seeking settlements of 90 cents on the dollar of what it has paid on behalf of the ill spouse. In the end, most cases settle anywhere from 65 cents to 85 cents for each dollar that Medicaid has paid out. Medicaid generally requires that settlement amounts be paid in one lump sum within 30 days from the date of settlement. While Medicaid is often unwilling to make exceptions for refusing spouses whose resources and/or income have been diminished or compromised due to their own medical needs, there are circumstances where Medicaid has been flexible in these issues.

Despite the risks involved in refusing to pay for the ill spouse's care, the advantages are still significant:

1. Medicaid may never commence a lawsuit (NYC HRA is the most aggressive local Social Service agency while Nassau and Westchester

Counties has begun pursuing these cases). While other counties are pursuing reimbursement, not every Medicaid office throughout New York State is pursuing reimbursement at this time.

2. Medicaid only seeks reimbursement on the amounts it has paid which is usually 70 cents on the dollar of what the refusing spouse would have had to pay the nursing home at the private pay rate. If a settlement is achieved, then in the end, the refusing spouse will pay about 50 cents on the dollar of what he or she would have paid if he or she did not execute a spousal refusal.

While defending spousal lawsuits does not require the litigation skills of Johnny Cochran, it is certainly helpful to have come from a litigation background in handling these matters. If you are asked to take on a spousal lawsuit and you have no litigation cap to put on, it may be advisable to refer the matter to a litigator who you should take time to educate on the issues of spousal refusal.

Finally, while the spousal lawsuit forum also raises the issue of the feasibility of engaging in post-eligibility planning on behalf of the refusing spouse, it is best to save a discussion on that very important topic for a later issue. In the interim, you will find an excellent article that impacts a post-eligibility planning in the Elder Law Section's *Advanced Issues in Elder Law*, Fall 1994 entitled "Rights of Recovery Against Estates and Fraudulent Conveyances."

Endnotes

1. *See also Commissioner of the Department of Social Services v. Spellman*, N.Y.L.J., February 10, 1997, p. 6, col. 6 (Sup. Ct., N.Y. Co. 1997).
2. 2000 N.Y. App Div Lexis 9032, 1st Dep't 2000, September 7, 2000.
3. *See also Commissioner of the Department of Social Services v. Fishman*, N.Y.L.J., July 23, 1998, p. 22, col. 3 (Sup. Ct., N.Y. Co.).

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