NYSBA FALL 2003 | VOL. 13 | NO. 4

Elder Law Attorney

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

Message from the Chair

Although this message will appear in the Fall edition of the *Elder Law Attorney*, I am writing to you on August 16th in beautiful Newport, Rhode Island, during our Summer Meeting. Lawrence Davidow, Program Chair and Vice Chair of the Section, deserves all the praise he is receiving for having assembled a stimulating program with practice nuggets for both novice and experienced elder law practitioners. In addition to providing 12.5 CLE credits and the opportunity for private Internet coaching, the Summer Meeting created a forum for spirited debate on ethical issues and strengthened collegial ties. Over 250 attendees enjoyed the setting, the programming and networking with the General Practice Section. Congratulations on a superb job, Lawrence! And thanks to Dwayne Weissman and Frank D'Angelo for the excellent collaboration with the General Practice Section.

The Summer Meeting's Substantive Program

The Summer Meeting's substantive program began with an update on elder law issues presented by past Chair Bernard A. Krooks, followed by Jay Kearns' tale of Medicaid penalty periods and waivers in Connecticut. The afternoon ended with a timely discussion on fiduciary appointment rules by Hon. A. Gail Prudenti, Presiding Justice of the Appellate Division, Second Department. A former Surrogate and Acting Supreme Court justice who heard Article 81 cases in Suffolk County, she entertained questions from the audience and offered her office to resolve problems arising from implementation of the new Part 36 rules.

Friday's program emphasized spousal issues. Ronald Spirn examined the Right of Election statute and presented planning opportunities with savings bonds, noting that New York State's inclusion of savings bonds as testamentary substitutes likely violates federal law. Howard Angione dramatized a consultation detailing Medicaid recovery issues and waivers of the right of election. Daniel Fish then dissected a spousal recovery suit, providing pleadings used in many of the reported decisions. The afternoon program, sponsored by the General Practice Section, highlighted procedures to follow in closing a law office.

Inside this Issue

Saturday morning's program was a pastiche of cutting-edge issues in elder law practice and planning. Stephen J. Silverberg gave concrete information on reverse mortgages and suggestions for dealing with co-ops. Ellyn Kravitz discussed ethical issues involved in transferring property to caregiving children or disabled children or spouses in a second marriage. The audience's debate on this topic carried through the coffee break, which was followed by Louis Pierro's detailed presentation on Medicaid's current treatment of IRAs and pension funds. Steven Stern then advised on the use of care contracts to secure payment for family members providing services for an elder law client. Charles Robert finished the program with a discussion of the new Ticket to Work Program for persons with disabilities and the Medicaid Buy-In Program, which will allow persons with disabilities to pay for Medicaid services even if they earn up to $42,000/year.

Proceedings of the Executive Committee: You're Invited

The Summer Meeting also includes an Executive Committee meeting which is open to all Section member attendees. Section policies are proposed and debated. This year's Meeting included a report from the Special Committee on Awards, headed by the Section's immediate past Chair Cora A. Alsante. Our Section will seek nominations from you, our members, for recipients of five different awards which will be presented to those who have served the elder law community in various ways. Nomination forms explaining the criteria will be available on our Section's Web site. The award recipients will be chosen annually by the three past Chairs of the Section.

Timing, location and substance of our various meetings have long occupied our Executive Committee. As I reported in my first message as Chair, a Special Task Force on Meetings is investigating ways to involve as many members as possible in our meetings, as mandated by our Long Range Plan. The Task Force recommended that the Fall Meeting be held in various locations around the state, with an Elder Law Institute included as a separate day of programs. A new Spring Meeting was proposed, to include the Advanced Institute, to be held in conjunction with the Executive Committee meeting in the spring. A final vote on these proposals will be held at the November 5th Executive Committee meeting.

Ronald Fatoullah, head of the Public Agency and Legislation Committee, discussed whether our Section should comment on the legislation proposed in the New York State Senate to extend Medicaid transfer penalties. The Public Agency and Legislation, Medicaid, and Legal Services and Nonprofit Organizations Committees, led by Ron Fatoullah, René Reixach and Valerie Bogart, will draft a commentary on the legislation for presentation to the Senate Committee in which the bill originated.

Committee Meetings and Agendas: Please Join a Committee and Call the Chairs to Help in the Projects

The Summer Meeting also offers a time for committee members to meet in person and crystallize their plans. Our Section encourages all members to join at least one committee. Simply notify our State Bar liaison, Lisa Bataille (lbataille@nysba.org) that you wish to become a member of a substantive committee, or contact the committee Chair, listed in this *Elder Law Attorney* and on our Web site.

It is my pleasure to share with you some of the plans of the committees that met in Newport. All of the committees welcome interested members to work on projects and seek assistance in identifying issues to address.

Client and Consumer Issues Committee: Margaret Z. Reed and Carol L. Scal

1. Continue the Mitch Rabbino Decision Making Day;
2. Develop a program concerning identity theft;
3. Develop a brochure on paying for long-term care with impartial assessments of long-term care insurance.

Family Law: Rita K. Gilbert and Lonya A. Gilbert

1. Investigate legislation in other jurisdictions protecting seniors against financial and physical abuse;
2. Upheaval of families as a result of nursing home placement;
3. Interrelationship between an attorney and a geriatric care manager;
4. Strategies for dealing with adult disabled children.

Guardianships and Fiduciaries: Robert Kruger, John Dietz, Anthony Enea and Ira Salzman

1. Uniformity in local practice;
2. Transition from guardianships to estates upon death;
3. Ways to simplify final accountings;
4. Create a Brief Bank;
5. Outreach to local bar associations concerning guardianship issues.

Persons Under Disability:

1. Develop a handbook for Trustees of Supplemental Needs Trusts, similar to the guardianship handbook developed in 2000;
2. Propose federal regulations for OBRA 1993 trusts;
3. Co-sponsor a program with CUNY Law School on SNTs.

Real Estate and Housing: Neil Rimsky and Marcia Boyd

1. Conduct a survey across the state as to housing options that are available in the various counties to identify what options exist and then see if legislative initiatives or outreach to various advocacy groups should follow in order to meet the needs of our clients.

We have a full agenda and seek your assistance in implementing it. You are the Section. We fulfill an important role in advocating for the rights of the elderly and persons with disabilities. Join a committee and work on a project. I believe that you will become as energized by the collaboration with your colleagues as were the attendees of the Summer Meeting. I hope to see you at the Fall Meeting at the Hudson Valley Resort and Spa.

Sincerely,

Joan Robert

Mitchell W. Rabbino Decision Making Day

Decision Making Day is to be renamed Mitchell W. Rabbino Decision Making Day in honor of Mitchell W. Rabbino, Esq., who died on February 14, 2003. Decision Making Day is sponsored by the NYSBA Elder Law Section. On this day, Section members volunteer their time to provide information about advance directives across New York State.

The Elder Law Section chose to honor Mitchell Rabbino by renaming Decision Making Day because he was such a valuable resource and active member of the Section. Most importantly, he embodied the dedication, civility, professionalism and integrity which made elder law attorneys proud to be his colleague. He was a much-respected member of the Executive Committee of the Elder Law Section for several years, serving as Treasurer and then Secretary. At the 2003 NYSBA Annual Meeting in January, Mitchell W. Rabbino was elected Chair-Elect of the Elder Law Section.

Those wanting to make a contribution in honor of Mitchell W. Rabbino may send their contribution to the New York Bar Foundation where donations will be put into a special fund to support Mitchell W. Rabbino Decision Making Day.

Editor's Message

Elder law is a unique, challenging and gratifying area of practice. It is also an area of constant change. With new case law, changes in regulations, changing procedures by administrative agencies, and new court rules, the practitioner must devote almost all of his or her time to learning and practicing in this area in order to provide the best legal advice and counsel. But elder law practitioners also know that the best representation requires some knowledge of several other disciplines in order to properly examine the goals and issues, and to offer the most appropriate advice. Many attorneys have had experience, personal and/or professional, dealing with related matters and can offer some insight and guidance. Others have not. Therefore, it is crucial that elder law attorneys either adequately learn other necessary skills or have the support of a network of allied professionals. The theme of this issue is Lessons from Other Professionals.

Barbara Wolford, LPN, and Director of Elder Care Services, has written an article concerning older adults with developmental disabilities. If you're not dealing with this population in your practice now, you soon will be, as the number of special needs clients who are aging increases. Ms. Wolford explains the challenges and options for aging special needs clients and their families.

Long-term care insurance is gaining in popularity, and should always be considered when discussing long-term care financing options with clients. Arlene Haims, CLU, ChFC, LUTCF, and Cindy Sipkin, MBA, CLU, have written an article outlining the important factors to consider in a long-term care insurance policy and some talking points to be used in the process. Al Clapp has written an in-depth article that examines the market, includes important statistics, and points out some of the strategies involved in considering and purchasing LTC insurance.

Reverse mortgages are becoming more popular as well. Dennis Haber has contributed an article that discusses the pros and cons of reverse mortgages, and how the practitioner should approach this option with his or her clients.

Estate tax laws are in flux, and many potential estate planning clients are reluctant to engage in sophisticated planning at this time. However, Mike Rosenberg, CPA, MBA, has written an article that explains the advantages of certain current events. With the unfortunate decline in asset values comes the opportunity to make estate planning transfers with little or no cost. The cost of not planning now in a favorable environment can be significant later.

Practitioners who attend national elder law programs know that the use of Medicaid-related annuities in other states is common. This strategy has been less prevalent in New York. However, changes in DSS policy and its more aggressive position toward refusing community spouses may require that practitioners consider their use in the near future. Dale Krause has written an article that explains how the right annuity can be a valuable tool when planning to protect assets.

Robert Grey, Esq. has significant experience in mediation and will contribute a column which focuses on mediation in an elder law context. Like all other areas of the law, mediation will become a more desirable course in the near future.

Please enjoy this issue of *Elder Law Attorney*.

Steven Stern

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ELDER LAW NEWS

REGULAR COLUMNS

Aging with Developmental Disabilities

By Barbara Wolford, LPN

As the number of older individuals with developmental disabilities increases, what do service providers need to have in place in order to provide excellent support and services to our clients and their families?

The definition of "developmental disability" by the Center on Human Developmental and Disabilities is a person who has at least one of the following conditions:

- Mental retardation
- Cerebral palsy
- Epilepsy
- Autism
- Neurological condition similar to mental retardation
- Disability must occur before the age of 18
- Must be expected to continue indefinitely and disability must result in a substantial impairment.

Generally, to be classified as developmentally disabled, the functional definition is that the condition must interfere with functioning in several life activity areas, such as caring for oneself, making life decisions and earning an income.

Adults with intellectual and related disorders are living longer and their numbers are increasing in proportion to the general older adult populations. Informed projections are difficult to make, because no specific data exists on the census of persons with developmental disabilities. However, it is estimated that tens of thousands of people nationwide are aging with disabilities and encompass two to three percent of the total U.S. population. A tripling by 2015 of the number of known older adults with lifelong disabilities is a reasonable estimate for the United States with increases in the millions anticipated nationwide. Some statistics estimate that for every 1,000 older persons in a geographical area, it is conjectured that approximately four individuals would be older persons with a developmental disability. This research does not take into consideration adults aged 40-59 (who often represent individuals with premature aging). During the next 15-20 years the needs of the newly "discovered" older adults—adults whose family caregivers have become incapacitated or died—will probably capture more of the time and resources of the aging and disability service systems. Those who will have invisibly grown older in the care of their families and those who have remained hidden by prolonged family caregiving will become more evident and in need of support and services. It is difficult to assess and determine how many of these adults are still living in the community with aged family members, because much depends on the family history of decision making, availability of independent housing and other geographical factors. Dr. Glen Fujiura and researchers at the University of Illinois estimate that 1.145 million adults with developmental disabilities over the age of 40 live with their parents or other family-related caregivers aged 60 or over.

Testimony to the Senate's Special Committee on Aging by Dr. Braddock in 2000 reported that approximately 1.9 million developmentally disabled adults are thought to live at home or with a family member. Dr. Braddock estimated that 25% of these caregivers are 60 years of age or older. He further reported that a large portion of in-home support is being provided by family members who will be aging beyond the capacity and ability to provide care over the next 10-20 years.

Medical advances and technology continue to emerge and develop, enabling all of us to live longer, including those individuals afflicted with intellectual and developmental disabilities. They and their caregivers are facing some of the same issues as the general older population. They wish to preserve their independence, maintain their levels of health and functional abilities and be able to access services and providers to assist them to age in place.

Two of the most significant reasons that developmentally disabled adults have reached later life are: advances in medications, and remaining in the community being cared for by family members. Because their parents are living longer the adult children may benefit from aging in place in community settings due to the fact that over the years the majority of peo-

ple with lifelong disabilities were not "institutionalized" but remained at home or living in some form of community environment. Medications have allowed persons with developmental disabilities to survive what once were often mid-life-threatening illnesses that would cause their demise. Medications also enable later onset health complications to be managed and prevent life-threatening complications.

The aging process for all individuals is affected by nature, etiology, severity of impairments, coexisting medical conditions, lifestyle and environmental factors. But, for the developmentally disabled older adult, secondary conditions can arise from the aging process along with their lifelong physical, mental and intellectual disability.

People who have mild and moderate levels of intellectual disability and no coexisting medical conditions can typically follow the same aging continuum as the general population. Adults who are more severely impaired and non-ambulatory are more likely to develop respiratory problems. Signs of aging may also start to appear as early as the age of 40, yet society as a whole does not expect these changes to become evident for at least another 20 years. After age 50 developmentally disabled adults are more likely to develop diabetes mellitus, arthritis, hypertension, cancer, and cardiovascular disease. Osteoporosis, obesity, and early vision and hearing loss often appear more prevalent in this population. Individuals who do not have Down's syndrome experience a gradual decline in overall intellectual capacity. It is believed that there is a correlation between Down's syndrome and a greater risk for Alzheimer's disease. The most frequent affect personality disorder can be depression that can be caused by lack of social acceptance, community limitations, an increase in the incidence of falls, dental problems, malnutrition, alcohol and smoking abuse.

Some potential differences between aging adults and the developmentally disabled community can include a smaller social network, fewer skills to maintain or create relationships, difficulty identifying and experiencing feelings of sadness, loss and grief. The wear and tear of dealing with life long disabilities can reduce the reservoir for later life medical conditions and physical impairments.

Service providers need to know how to assess these age-related changes and support the person's changing needs. Often there is a lack of coordination between service providers and the immediate and long-term needs of clients and their families. Older family caregivers have concerns about planning for the future for the loved one and who will care for their adult child if they become incapacitated or die. Key service needs reported by older family caregivers are: information regarding residential programs, legal issues, financial plans, guardianship, and respite services.

"Professional networking encourages us to think out of the box, looking at issues and concerns, exploring options that we may not be aware of or able to identify."

In many communities, older adults with developmental disabilities participate in services provided by the aging network (i.e., senior centers, adult day care programs, nutritional sites). The Older Americans Act was instrumental in providing legislative support to include older persons with developmental disabilities in the services provided under the Act. Some of the requirements of the act included state and local agencies being mandated to cooperatively plan and develop services for developmentally disabled adults, such as allowing adults under the age of 60 to be served at congregate meals sites while accompanying their eligible parent or caregiver, home-delivered meals, homemaker services and case coordination.

Partnership initiatives between the aging and developmental state agencies can help implement regional or local disability-related activities under the National Family Caregiver Support Program. A sample of these partnerships could be developing local networks, sharing staff, and organizing the community and networking groups to develop tasks forces that can examine the problems that are common to both the aging adult and developmentally disabled adult.

Professional networking encourages us to think out of the box, looking at issues and concerns, exploring options that we may not be aware of or able to identify. It allows us the ability to establish relationships outside of our own disciplines and cultivates strong working relationships. Networking can help to assess and identify common concerns, problems, and issues and encourages building a constituency that will allow support and influence, and open doors to mutual opportunities, generating activity and hopefully positive outcomes. Networking enhances the

potential to exchange information and referrals and form a coalition that will strengthen our desires to work together.

Coalition building is more formalized than networking and consists of professional and family advocates, service providers, agencies, and private and public officials that undertake a grassroots effort to spearhead the undertaking of a larger task. Positive outcomes have been achieved by joining multiple networking groups and utilizing existing agencies from the aging and developmental disability arenas to develop common campaigns to develop programs and services and obtain funding for the aging population with varied needs.

As professionals we need to understand the need for an interdisciplinary approach and analysis of the diversified needs and rights of older adults with developmental disabilities. Our clients will need advice and guidance on critical issues that arise as their loved one's condition changes. Their concerns will evolve around legal, financial, human rights and self-determination concerns. The service providers of our clients may also seek our wisdom and expertise on issues that involve financial planning and capacity issues.

People with developmental disabilities of any age and their families have been very clear in advocating for the increased dignity, respect, choice, control, relationships and opportunities to remain in the least restrictive environment and be offered the same services and programs of the aging population. Health care providers should be cognizant that older adults with developmental disabilities are not a homogenous group.

As providers, we need to address the concerns and issues that aging persons and their caregivers encounter on a daily and long-term basis. We must promote education, understanding and empowerment to identify the ever growing population of older adults with developmental disabilities and their aging caregivers. By providing information and supporting decision making of the aging adult we can assist our clients in making informed and appropriate choices to plan for their futures. This support should include explaining medical procedures, providing reassurance, coordinating family involvement, and assisting with the transition to new environmental and living arrangements. Professional partnerships ought to be built on an individual basis and should benefit members of the client's team of caregivers with the knowledge of the diverse needs of each client. We need to explore the blending and coordination of services to reach even the most severely disabled adult.

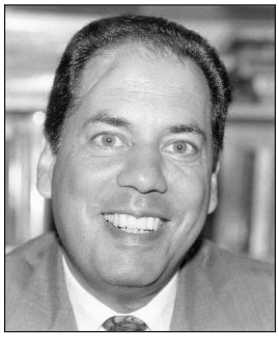
Our future health care and legal systems will be challenged with providing the highest level of quality care and services to all of the aging populations. Meeting this challenge is the responsibility of the professional continuum and should be incorporated into our standards of practice.

It is imperative that we look to shift the paradigm for all involved—a movement that will enrich the lives of people with developmental disabilities and protect their human rights.

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

A Primer on Reverse Mortgages: How the Benefits Can Change Your Clients' Lives . . . Forever

By Dennis Haber



This article will acquaint you with a vastly superior financial tool that your senior clients should consider. It has the potential to make their lives measurably better. The first part of this article will discuss why a reverse mortgage should be a potent weapon in your clients' financial problem-solving arsenal. The second part will tackle the specific features and requirements indigenous to reverse mortgages. Part three will address the misconceptions that often prevent a senior from realizing financial independence.

As of this writing, the term "reverse mortgage" generally refers to any one of three distinct reverse mortgage programs that are utilized nationally. By far, the most popular is FHA's Home Equity Conversion Mortgage (HECM). The other two programs are based in part upon the HECM. Accordingly, since the HECM accounts for 95%[1] of all reverse mortgage loans, we will likewise use this program for our discussion. The other national programs will be mentioned later in this article.

There is currently a bill in the New York State Assembly[2] that will permit the New York State Mortgage Agency to implement New York's unique reverse mortgage law.[3] The real importance of this law is that it permits and recognizes the HECM loan in the state of New York,[4] the mortgage recording tax is waived,[5] and proceeds from a reverse mortgage are not considered income for purposes of determining eligibility for public benefits or social services programs.[6]

New York first recognized reverse mortgages in 1984.[7] However, banks in New York had not embraced this type of loan because of the outstanding question of lien priority.[8] In 1993 this issue was put to rest.[9] Practically speaking, reverse mortgages have been accepted in New York for about a decade. The abundant, powerful opportunities inherent in reverse mortgage financing are starting to be noticed by seniors, their accountants, elder law and estate attorneys, insurance agents and their financial planners. The steady increase in closed reverse mortgage loans has caused the government to increase the number of reverse mortgages the government can insure.[10]

Join me on this brief journey of discovery, as I show you how you can truly make the lives of your clients happier and stress-free by removing the financial worries that typically cause the "golden years" to turn into those "olden years."

Part I

A forward mortgage is the kind of loan you are familiar with. Monthly payments are made to a bank. As those payments are made, the unpaid principal balance decreases (amortizes), while the equity in the home continues to grow. This kind of loan is commonplace. With a reverse mortgage, the opposite occurs. The bank pays the borrower each month (if the borrower chooses this type of payment) while the equity in the home decreases. This kind of loan is quite remarkable as it literally "manufactures" money the senior would otherwise not have access to. Accordingly it allows them to fulfill their heretofore unrealized dreams. Among the largest untapped assets a senior has is the equity in their home.[11]

Both types of loans (forward and reverse mortgages) also have due on sale clauses. Such clauses trigger acceleration of the loan. In a forward mortgage the use of same is limited to certain narrow specific circumstances. Let us compare a common situation. When a child's name is added to the deed, it usually will not trigger acceleration in a forward mortgage.[12] However, in a reverse mortgage, transfer to a child causes the loan to become due.[13] Generally the parties in title must be of reverse mortgage age.[14] In fact, the Office of Thrift and Supervision acknowledges that those situations that would not cause a due on sale clause to be activated in a forward mortgage would have the opposite effect upon a reverse mortgage.[15]

Today, many seniors are literally sitting on a gold mine. Yet seniors, after having paid off their original mortgage, or having significantly paid down the balance, no longer wish to be burdened with those monthly mortgage payments. Selling is not an option, either. Many seniors have lived in their homes for many years and do not want to move.[16]

The reverse mortgage can eliminate the economic hardship seniors are facing.[17] Specifically, financial hardships due to illness and long-term care issues, along with misinformation about the Medicare and Medicaid programs, place many seniors in a precarious financial position. The reverse mortgage was created to address the financial profile of seniors who are on fixed incomes and face ever-increasing housing, health and living expense costs.

"The reverse mortgage can eliminate the economic hardship seniors are facing[—] . . . financial hardships due to illness and long-term care issues, along with misinformation about the Medicare and Medicaid programs . . ."

Many seniors do not wish to move because they find comfort in the familiar. Familiarity becomes especially important to those seniors that suffer from macular degeneration, which is the leading cause of legal blindness in seniors age 65 and over. It affects about 33% of the senior population in this age bracket.[18] Staying in their home provides them with a huge sense of security and independence. Eighty-five percent of seniors 65 and over have at least one chronic illness while 30 percent over age 85 have three or more chronic illnesses.[19] More importantly, the home could provide the senior with the source of funds to maintain their lives with the utmost dignity.

Because seniors are living longer, they have a higher risk of requiring long-term care. Ten percent of seniors who reach age 65 will suffer from Alzheimer's, while 47 percent over 85 will suffer from the same malady.[20] Most seniors, by the time they reach 65, will suffer from at least one chronic illness. This may affect one or more activities of daily living. Over 80% of seniors that have not purchased long-term care insurance have given the cost as a reason. A reverse mortgage allows seniors to at least consider obtaining a long-term care policy.

Broadly speaking, Medicare will pay for skilled nursing care and in-patient hospital care. It will also pay for skilled home care and hospice care. Different rules apply to each. Medicare is the government's answer to health care insurance. Because it is insurance, the government pays only a portion of a claimant's bills. Each insured is responsible for the yearly deductible and daily co-insurance under Part A and the remaining 20% of the doctor bills under Part B. You can see why it is important for an individual to purchase private health coverage to cover the costs the government does not pick up. Medicare's payment to hospitals is diagnosis-based. This means that the hospital gets paid the same amount if a patient is in the hospital for two days or seven days. There is a great incentive for hospitals to discharge the patient as quickly as possible. Again the need for long-term care becomes critical. Reverse mortgage financing is a perfect way to create the funds to pay for this kind of insurance.

Medicare will only pay for 100 days of skilled nursing home care per benefit period. It covers 100% of the first 20 days. From day 21-100, Medicare will pay everything but the daily co-insurance amount. This amount could grow to over $8,000. Many seniors wrongly believe that the government will pick up the total cost of their "skilled" nursing home care. Seniors must continually reach into their pockets, either to purchase supplemental insurance or pay the daily co-insurance. In addition to this, they need funds to pay for the cost of prescription drugs. Where can they get their hands on additional funds? The answer is a reverse mortgage.

The financial and emotional toll of aging can cause havoc within the family unit. Children that have children of their own have the added financial and sometimes physical burden in meeting the needs of the parent. Children are forced to become caregivers because funds are scarce. About 20% of family caregivers spend 40 hours per week caring for their loved ones.[21] Sometimes children will sacrifice promotions at work, or may have to quit a job to take care of Mom and or Dad. It is not unusual for a child to suffer from burnout soon after taking on this responsibility. If another sibling is not available to lend a hand or respite care is not affordable, then the impending situation is a recipe for disaster. It is estimated that some of the "sandwich generation" will spend more time providing eldercare than child care. The question: How can parents regain their independence and release their children to live their lives? Again, the answer is a reverse mortgage.

Incredibly, the growth in the senior marketplace is occurring in the 85-and-over age range. According to the last census,[22] 72,000 people reached 100 years of age. In 2000, the life expectancy reached 76. Compare this to the life expectancy in 1900 of 47 years. People are living longer. Accordingly, their money must last longer as well. With the spate of bad investments, rising property taxes, poor financial planning, and low return on investments, seniors on all economic levels are having a difficult time. The question becomes how seniors can get more money into their pockets quickly. And again the answer is a reverse mortgage.

The best news is that reverse mortgage approval is not based upon a showing of specific income, liquid assets, nor a showing of creditworthiness. The only credit caveat is that judgments and liens must be paid at or before closing and any bankruptcy must be discharged. If a senior had to go through the typical underwriting process, many couldn't qualify for a forward mortgage. But they can qualify for a reverse mortgage.

In essence, when one chooses a reverse mortgage, a non-performing "dead" asset is transposed into a performing "live" asset. The senior can unlock the equity in the home that is just sitting there doing nothing. Before a reverse mortgage was on the radar scope of seniors, seniors who couldn't qualify for a loan could only realize the significant equity by the sale of the home. A reverse mortgage affords them the opportunity to remain in the home that they love. Let us look more closely at why selling the home and obtaining a traditional mortgage are not acceptable choices for an overwhelming majority of senior citizens.

Choice #1: A Senior Can Sell Their Home

REASONS WHY THIS CHOICE DOES NOT WORK: Statistics show that seniors do not want to move. Their goal is to stay in the environment that contains so much of their personal and family history. They want to live in an area that is familiar. Often the house is the center of the story of their life.

After the home is sold, the senior has to find a new place to live. Very often a new, smaller home will cost more than the home they just sold. Often they do not have the money for the down payment or the funds to cover the closing costs. Even if a senior could move, often the emotional toll is devastating. As you can see, a sale becomes financially impractical. Leasing new quarters also creates anxiety because the senior is also forced to give up the place that stores so many of their memories. When leasing, they are subject to rules and regulations of the apartment complex. When considering these choices, the undercurrent of thought remains that they prefer to stay in their current home.

Choice #2: A Senior Can Get a Traditional Loan

REASONS WHY THIS CHOICE DOES NOT WORK: Typically when one applies for a mortgage, income, assets and credit are reviewed. Front end and back end ratios are determined. Credit scores are carefully perused. While some seniors may in fact be able to qualify for a traditional loan, they do not want the "headache" or the responsibility of paying it back. Making those monthly payments is something they can do without.

Many seniors, on the other hand, cannot qualify for a loan. They do not have the income and/or the assets and/or the credit to be approved for a traditional mortgage.

A reverse mortgage works because a senior receives a sum of money from a bank without having to make those dreaded monthly payments.[23] As long as the home is used as a primary residence,[24] the property taxes are paid,[25] the homeowners insurance is paid,[26] and the property is kept in good repair,[27] the loan does not have to be repaid. When the last (spouse) homeowner passes away,[28] or does not use the property as their primary residence,[29] then the loan will be repaid. At this time, the home is put on the market. Notice the difference. The home is sold by the senior or their estate when the senior no longer has a use for the home.

A reverse mortgage has the pliability and flexibility to meet many needs of the senior borrower. For example, one reverse mortgage program permits title in a trust,[30] retained life estate,[31] or leasehold interest.[32] The tax-free proceeds[33] can provide enough money to purchase a long-term care policy, or other insurance as discussed above. The funds can act as an emergency investment vehicle, an estate planning device, or a retirement facilitator.

You are probably wondering what could be stopping a senior from moving forward. The issue that stops them dead in their tracks is a personal one. It is the delicate issue of inheritance. Some seniors feel an obligation to leave their home "mortgage free" to their children. Some children will insist that their parents refrain from obtaining a reverse mortgage

because they want to receive the home free and clear when the parent dies.

On the other hand, many children would also rather see their parents live a life of independence and dignity. They encourage their parents to obtain a reverse mortgage. In fact, a reverse mortgage is a life-saver for the senior as well as the children. When the parent gets a reverse mortgage, the children do not have to provide money to their parents. It alleviates the burden the children feel, as they usually have children of their own. Accordingly, they may be contributing to a college fund for their kids' educations, or a retirement fund for themselves. They are strapped. Many really are not in a position to help their parents. Therefore, a reverse mortgage often turns out to be a real life saver for both sets of families.

Part II

Reverse Mortgage Requirements (HECM)

This section will focus upon the specific requirements mentioned in the previous section.

A reverse mortgage is unique because the loan does not have to be repaid until the home is sold; the senior dies or permanently leaves the residence.[34] No monthly payments are ever made by the senior borrower. At the time the loan becomes due and payable the heirs can either choose to repay the loan and keep the house or sell the home or keep the balance of the remaining equity. *The choice is always theirs.* There is no personal liability on the note.[35]

The amount a borrower can receive depends upon the age of the youngest borrower, the value of the home and the current interest rate. The minimum age requirement to obtain a reverse mortgage is 62.[36] The age of the youngest borrower is used when there are two borrowers.[37] It is important to remember that the older the borrower is, the more money can be obtained. For example, assuming the same housing value, in the same community, a 75-year-old can extract more equity than a 65-year-old borrower.

The tax-free proceeds from a reverse mortgage can be received in a variety of ways. The borrower can choose a lump sum or monthly payments for as long as they live in the home or monthly payments for a term of years, or a line of credit.[38] These options can even be combined, The absolutely remarkable thing about these payments is that the payments will last even if the total payments exceed the original principal limit and exceed the amount noted in the security instrument.[39] Unlike other programs, there is no minimum draw (tenure, term or credit line) that a borrower is required to take.[40] They can even switch between payment options.[41] Again, let me reiterate that a reverse mortgage is very flexible. It is like a straw that can be bent, twisted and molded to fit borrowers' needs.

The borrower has sole and total discretion when it comes to using the proceeds. Accordingly, seniors have used the proceeds to make needed home repairs, pay off credit card debt, judgments, mortgages and tax liens. Some have used the proceeds for home health care requirements. Others have purchased second homes, or traveled to their favorite places. The money can even be used to provide for a grandchild's college education. Some have even purchased different types of insurance policies. Remember, a fundamental purpose of the reverse mortgage is to allow seniors to dream again of a better life for themselves and for their family. It is important that they realize those dreams while maintaining their independence. A reverse mortgage accomplishes these feats.

Although the qualification process is easy, a reverse mortgage applicant must attend or receive reverse mortgage counseling from an approved (HUD) counseling agency before the process can go forward.[42] This is a good thing as it provides the seniors with additional information as well as possible alternatives to their situation. More importantly, it insures that the seniors are doing the right thing. I personally believe in getting family members together to discuss the situation. It is important that the entire family understand the benefits of this wonderful program.

As noted at the beginning of this article, there are several distinct types of reverse mortgage loans. The HECM loan comes in two varieties. The interest rate can adjust monthly or yearly. The other loan type is Fannie Mae's Homekeeper loan. Generally this program is more conservative than the HECM. Usually the proceeds are greater from the HECM program, in a jurisdiction where the maximum claim amount is HUD's maximum lending limit.[43] The third type of program is the Cash Account. This is a proprietary program owned by Lehman Bros. Financial Freedom Senior Funding Corp., a wholly owned subsidiary of Lehman Bros. Under this program, a senior can realize even more equity. It generally works best when the home has an appraised value that exceeds $500,000 and the senior is in their mid- to late-70s. Also this program can be used for co-ops and irrevo-

cable trusts. While all reverse mortgage loans are adjustable rate loans, the HECM loans are tied to the one-year Treasury rate. Each HECM type has a different margin and yearly or lifetime caps.

A reverse mortgage loan can only be made against a principal residence.[44] FHA will make a loan against a 1-4 family unit, approved condos and PUDs.[45] However, single-family lending limits are used in 2-4 unit properties. Fannie Mae will make loans against 1-unit properties only, approved condos and PUDs. As mentioned above, a reverse mortgage program recently became available for co-ops, under the Cash Account program. It is hoped that within a year, FHA and Fannie Mae will also permit reverse mortgages on co-ops.

Sometimes, repairs are required to be made on the home. Small repairs of $500 or less must be made prior to closing. Repairs greater than $500 but not exceeding 15% of the home value (maximum claim amount)[46] can be made within six months of closing. Structural termite repair must be made prior to closing, while non-structural repair should be completed within 90 days of closing.[47]

Part III

Reverse Mortgage Misconceptions

Unfortunately, family and friends still promulgate wrong information about this program. Sometimes, the attitude of family and friends will prevent those whose problems can be solved by obtaining a reverse mortgage from going forward. It is a sorry sight to watch this happen. Then the question is, why do seniors shy away from a program that can give them the financial independence they crave? The answer is that there are many misconceptions about reverse mortgages that get repeated again and again. Like anything that gets repeated, people start to believe what they hear.

Let's clear up these misconceptions once and for all and review the salient points.

a. The borrower must make monthly payments.
THE TRUTH: The borrower never makes a monthly payment.

b. The bank owns the house.
THE TRUTH: The borrower continues to own the home. The bank does not own the home.

c. The heirs will be responsible for repaying the loan.
THE TRUTH: A reverse mortgage loan is a non-recourse loan. This means that the borrower(s) as well as their heirs are not personally responsible for repaying the loan. In the event the sale proceeds do not cover the amount due on the mortgage, the bank has to accept this lesser payment as payment in full.

d. Closing costs are too expensive.
THE TRUTH: While the actual closing cost figures may be a little higher than typical FHA closing costs, it is important to remember that these costs can be financed. The main reason for this higher cost is that the HECM reverse mortgage plan requires 2% rather than 1.5% mortgage insurance.[48] Generally, the only upfront fee that is out of pocket is the appraisal fee. Also keep in mind that a senior is obtaining a loan that does not require income, asset or credit underwriting approval and they do not have to make monthly payments. Also note that two mortgages are recorded. The second mortgage is HUD's.[49]
Question: If you had an opportunity to get a loan and didn't have to make a payment during your life, would you consider it? Well, this is an opportunity for seniors to regain their independence and dignity. When you focus only on closing costs and the TALC (similar to an APR-annual percentage rate), you are missing the bigger and more important picture.

e. The loan is due and payable when the first borrower dies.
THE TRUTH: The loan is not due and payable until the *last* surviving borrower dies, sells the home or leaves the residence.[50] In fact the loan can be prepaid at any time.[51]

f. Benefits received from Social Security, Medicare and Medicaid are affected.
THE TRUTH: These benefits *are not* affected by a reverse mortgage loan.[52]

g. Reverse mortgages are only for seniors who are poor, or for seniors who find themselves in dire financial situations.
THE TRUTH: Seniors in every economic stratum and from all walks of life are taking advantage of the benefits offered by reverse mortgages.

h. Reverse mortgages offer no benefits to those who want to leave their homes to their children mortgage-free.

THE TRUTH: Seniors can enjoy the cash flow that is created by reverse mortgages and they can still leave their home mortgage free to their children by combining guaranteed death benefit life insurance with the reverse mortgage. In the meantime, the seniors are living a life complete with dignity, while their children are relieved of the financial responsibility for their care.

i. Reverse mortgages are not necessary since a senior can always do Medicaid planning to pay for the exorbitant costs of long-term care.
THE TRUTH: Medicaid planning can be risky in that it involves transferring assets out of a person's name to children or to a trust. This generally puts the money out of reach of the parent and, in the case of outright gifts to the children, exposes the money to claims by creditors of the children. The money can also become an issue when children divorce. It is important to note that the government has been trying to restrict Medicaid eligibility for years. There is no guarantee that the program will remain viable in the future. Reverse mortgages offer a way to assist Medicaid planning by taking money out of the house today while starting the running of the look-back period. Should the senior then need the services of a nursing home, they have used the reverse mortgage funds to temporarily or permanently take care of their long-term care needs.

j. A senior must enjoy good health to qualify for a reverse mortgage.
THE TRUTH: Unlike long-term care insurance, reverse mortgages are not medically underwritten. One of the most pressing issues and questions facing our growing senior population is how to effectively finance the out-of-control costs of long-term care. A reverse mortgage can help accomplish this goal. These proceeds can be used either as the sole payment source for an aide or as a supplement to the hours received for home care benefits through Medicaid. For example, if Medicaid authorized twelve hours of care a day but the individual actually needs care twenty four hours a day to safely remain in the home, the proceeds of a reverse mortgage can be used to pay for the additional twelve hours of care a day. Taking into account all the reverse mortgage variables, a senior may very well be able to live their final years at home and avoid nursing home placement. This allows seniors to maintain their dignity and control over their long-term care. Although Medicaid generally considers an individual's income and assets in determining a person's eligibility, the good news is that the proceeds of a reverse mortgage are not counted under New York State law as a countable resource for Medicaid purposes.

Now it is time to weigh the facts. I believe that reverse mortgage financing offers senior citizens flexibility to make the best out of their remaining years. The sole purpose of this article was to educate and debunk the misinformation that surrounds the exciting topic of reverse mortgages. This type of loan is safe.[53] It has government support. It allows our seniors to use the equity in their home to realize their dreams and possibly finance long-term care, in such a manner which allows them to remain in the home. Seniors are beginning to understand that age does in fact have its privileges. Imagine getting a loan without a requirement that you pay the bank each month. Further imagine that you never have to make a payment for as long as you live in your principal residence. Think about all the things a senior can accomplish with a reverse mortgage. All of a sudden, many more people wish they were at least 62, because they, too, do not want the stress of making those monthly mortgage payments and want to dream again. Now you can help your clients dream those wonderful dreams. You have the power to make a better life for your senior clients. All you have to do is explore the possibility of a reverse mortgage. It is really that simple.

Endnotes

1. National Reverse Mortgage Lenders Association news release, Oct. 17, 2002
2. Bill A.03328—An act to amend the public authorities law, in relation to authorizing the state of New York Mortgage Agency to issue reverse mortgage loans. It is also an attempt to get more New York State lenders to enter the reverse mortgage market.
3. While New York's scheme is confusing at best (it sets up two different age groups, with each having a different set of qualifying criteria: 60-year-olds and older and 70-year-olds and over), it has different definitions for a "term reverse mortgage" as it relates to the above age groups. It also requires an equal number of reverse mortgages to be closed for these two groups. A difficult task, considering that all national plans require the homeowner to be at least 62 years of age. However, it does clarify some important points. See text.
4. RPL §§ 280(4), 280a(4).
5. Tax Law § 252-a(2).

6. Social Services Law § 131-x.
7. RPL § 280.
8. RPL §§ 280(5), 280a(5).
9. 1996 Op. Att'y Gen., N.Y. 16.
10. HUD authorized 150,000 reverse mortgages, 12 U.S.C. § 1715z20(g). The number of HECM reverse mortgages has increased by 68% from fiscal year 2001 according to an Oct. 17, 2002 news release by the National Reverse Mortgage Lenders Association.
11. According to the American Housing Survey for the United States (1997), 77% of older homeowners owned their home free.
12. 12 U.S.C. § 1701j-3(b)(1).
13. 24 C.F.R. § 206.33.
14. In a life estate the life tenants must be 62. The remaindermen can be younger. 24 C.F.R. § .27(c).
15. 12 C.F.R. § 591.5(b)(1).
16. AARP survey 1996 as reported by syndicated columnist Kenneth R. Harney in the Oct. 25 edition of The Daily Record. Eighty-one per cent of people over 50 do not want to move.
17. 12 U.S.C. § 1715z-20(a).
18. Society of Certified Senior Advisors, 2002 ed., p. 36.
19. *Id.* at 79.
20. Alzheimer's Association (1996).
21. Society of Certified Senior Advisors, 2002 ed., p. 178.
22. U.S. Census Bureau International Data Base, 2000.
23. 24 C.F.R. § 206.27(8).
24. 24 C.F.R. § 206.27(2)(i), 24 C.F.R. § 27(2)(ii), 24 C.F.R. § 206.3 and 24 C.F.R. § 26.39.
25. 24 C.F.R. § 206.27(6).
26. 24 C.F.R. § 206.27(6).
27. 24 C.F.R. § 206.27(5).
28. 24 C.F.R. § 206.27(c).
29. 24 C.F.R. § 206.27(2)(i).
30. Mortgagee Letter 93-22.
31. 24 C.F.R. § 206.27(c).
32. 24 C.F.R. § 206.27(c).
33. Proceeds from a loan are not considered income.
34. 12 U.S.C. § 1715z-20(j).
35. 12 U.S.C. § 1715z-20(d)(7); 24 C.F.R. § 206.27(8).
36. 24 C.F.R. § 206.33.
37. 24 C.F.R. § 206.33.
38. 24 C.F.R. § 206.25.
39. 24 C.F.R. § 206.19(a)(b)(c). In spite of the language in (f), FHA does not keep track of the amount noted in the security instruments, and therefore will continue to make payments until the term expires, the credit line is depleted or the home is sold in the case of tenure payments.
40. 24 C.F.R. § 206.25(g).
41. 24 C.F.R. § 206.26(c).
42. 24 C.F.R. § 206.41.
43. As of this writing the HUD maximum lending limit for a single family home is $280,749.
44. 24 C.F.R. § 206.3.
45. 24 C.F.R. § 206.45; Mortgagee Letter 90-17 (I); Mortgagee Letter 96-15; 24 C.F.R. § 206.51; 12 U.S.C. § 1715z-20(d)(3).
46. 24 C.F.R. § 206.47.
47. Financial Freedom Training Manual.
48. 24 C.F.R. § 206.105.
49. See note 52 *infra*. The recording of this mortgage allows the HUD Secretary to have a lien in the event HUD is required to make the payments to the senior.
50. 24 C.F.R. §§ 206.27(2)(i)(iii), 206.27(c).
51. 24 C.F.R. § 206.27(b)(4); *see also* IRS Rev. Ruling 80-248 regarding deductibility of interest.
52. Social Services Law § 131-x.
53. There are safeguards to insure that the senior receives their money from their lender on time. The Secretary of HUD under 24 C.F.R. § 206.121 can investigate the particular complaint; order sanctions against the lender under 24 C.F.R. § 206.201 and under 24 C.F.R. § 206.117 can take action to make sure a mortgagor gets their appropriate payment(s) under such circumstance.

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Flexible Planning Choices for Long-term Care

By Arlene K. Haims, CLU, ChFC, LUTCF and Cindy G. Sipkin, MBA, CLU

Arlene K. Haims

Family matters such as planning for an elderly relative's well-being are often the last topic for discussion in family circles. Unfortunately clients finally present themselves to professionals during a crisis when living arrangements and care decisions need to be made with haste and when cost of care becomes the prevalent factor. Ideally, money should never stand in the way of an individual's care decisions.

"The financial burden of a long illness can make even those of moderate means poor."

The most important reason to plan for any stage of life is to protect one's independence and maintain control over assets and care decisions. Long-term care insurance has very recently taken on a major role in cost sharing for those difficult life moments. The financial burden of a long illness can make even those of moderate means poor. The client with a larger net worth will also bear a great burden, as many will watch their estate diminish greatly when a spouse requires care for a long illness.

Prudent retirement and estate planning would require that these issues be discussed and dealt with. Long-term care planning can be simplified. Following are a few simple facts to ponder:

- As with any insurance, plan for the probability, not the possibility. That includes having some portion of the risk of becoming ill transferred to an insurance company.
- Employers can provide a substantial voluntary benefit for both employer and employee. Carve-out plans can allow executives to receive richer plans, while group insurance can insure that employees and their families have peace of mind as well. Discounts and tax incentives make group planning easy for an employer to sponsor. Benefits can be used to keep employees loyal.
- Although Medicaid has been a useful tool in funding family care issues, Medicaid programs lack proper funding and clients should be made aware of the pitfalls of assuming that Medicaid will pay for their needs. Medicaid is not always the most appropriate plan.
- When reviewing long-term care insurance plans, clients should be interviewed regarding their health history well *before* any plans are reviewed, after which at least three or four companies that might be interested in taking the insurance risk should be reviewed.
- Clients purchasing insurance below the age of 65 must be sure that they will still be able to afford the premiums after retirement.
- Individuals using insurance as part of their estate plan will find useful tools that reduce premium payments to a one-time premium. Shifting a small percentage of assets to a funding vehicle that will purchase insurance lowers overall costs and provides significant asset protection.
- Individuals with less money to spend might consider a bare-bones program that some companies will offer. New Jersey residents can purchase a family care plan that uses a pot of money to cover whomever in the family will need coverage.
- Agreeing to use care advisors can help to extend benefits by using less costly services.
- Cost-of-living riders are important but quite often a very large percentage of premiums. It is usually recommended that persons under age 65 should consider compound interest inflation protection while older individuals should consider simple interest benefits or none at all. With older clients it might be better to choose a

higher daily benefit now than to wait for a rider to increase the benefit in future years.

- Plans should be properly designed by reviewing cost differentials for optional benefits. For example: waiving the elimination period for home health care will add approximately 9% to the insurance premium. Shared care, which allows a pool of benefits to be used for two spouses, will add 8% and survivorship waiver of premium benefits will add 9%.
- Special needs for clients such as international benefits and benefits for gay partnerships can be included in a well-planned design.

Careful assessment of a client's special situation, so that the right tools can be utilized, will go a long way toward safeguarding independence, maintaining control over care decisions and protecting assets. This kind of lifestage planning will not only reduce financial burden but will also provide dignity for families.

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Long-term Care Insurance Role and Outlook

(NY NAELA Newsletter 8-9-03)

By Alfred C. Clapp, Jr.

Following is a discussion of LTCI value, market, coverage, home care reimbursement limitations, issues, and strategies to help clients make better choices and to support diverse aging needs.

The need to develop comprehensive **Long-Term Care (LTC)** plans and to consider **Long-Term Care Insurance (LTCI)** as an essential valuable component of retirement and estate plans, has been increasingly recognized, but, nevertheless such plans all too often overlook the possibility that the elderly may become incognitive or incapacitated. Moreover, as the nation's growing numbers of over-age-60 seniors face sobering potential threats to their financial survival, it has become compelling to consider LTCI long before retirement to plan ahead for the over 40% risk of serious incapacity—and probably high costs associated with it—as people age.

LTCI coverage has grown at an 18% **Compound Annual Growth Rate (CAGR**) since its introduction a quarter of a century ago. However, with the growing shortage of caregivers and their inevitably higher costs, the fact that only a few companies and their LTCI policies permit an insured to hire a private caregiver greatly limits coverage. LTCI policies also are difficult to analyze, compare and buy—as well as to sell. In today's difficult market environment, as companies offering LTCI are consolidating, resulting in a few large, financially stronger companies being expected to have stronger positions in individual and group markets, it is essential to evaluate and recognize what are the stronger companies. The surviving companies are reevaluating LTCI's potential and profitability, offering better coverage, while at the same time tightening underwriting and increasing premiums.

Current Market and Coverage: Market Size. At year-end 2002, according to LIMRA International, 3.8 million individual and 1.5 million group policies, a total of 5.3 million policies, were in force, while premiums in force totaled $6.9 billion, $6 billion individual and $0.9 billion group. In comparison with larger established insurance product lines, LTCI is a small, new product. LTCI's expected long-term growth is less favorable than was projected in the 1990s. However, the outlook for its growth remains favorable, given that such policies should become more valuable components of retirement plans.

Leading Companies. At year-end 2002, according to a Life Span survey of policies in force, GE accounted for 26% of the LTCI market and Hancock 13%. Four companies had about 8% each: CNA, Bankers Life and Casualty, bankrupt Conseco, and AEGON. The companies with the next five largest market shares are bankrupt Penn Treaty, UNUMProvident, IDS, Met Life, and Allianz Life, accounting for a total of 21%.

Group Policies. Group plans have attracted younger persons. Initially company sponsored group plans may guarantee otherwise uninsurable individuals. Many group plans have offered poorer, higher priced coverage in comparison with the better individual policies. The federal government Long-Term Care Program, underwritten by John Hancock and Met Life, offered only a 75% home care reimbursement policy to over 20 million enrollees. Despite heavy promotion in the first quarter of 2003, only 265,000 persons, or 1% of the maximum number, enrolled. LTCI's enrollment in group plans has been greatly curtailed by federal tax policy that does not permit premiums to be deducted in cafeteria plans. **(STRATEGY: As many group plans offer poorer coverage in comparison with the better individually underwritten policies, compare group policies with individual ones.)**

NY Partnership. The NY Partnership, started in 1993, offered a very competitively priced reimbursement policy which provides either six years (home or assisted living facility (ALF) care) or three years nursing home care as well as any combination of these choices on the basis of a nursing home year being equal to two years at home or in an ALF. From the outset to today, most of the private insurance company policies only offered the minimum 50% home care coverage in relation to a 100% nursing home care coverage. The NY Partnership protects all

assets (not income) from Medicaid recoupment. In New York State, only about 38,000 policies have been sold. (**STRATEGY: An insured on benefit may transfer income-producing assets with this New York policy to a family or other donee(s) in order to protect assets after a policy coverage ends.)**

Economic, Affordability, Health, Disability Income Trends Impacting LTCI

The issues that face LTCI buyers and sellers started in recent years with the following major trends, and they continue to affect LTCI's acceptance, effectiveness and affordability.

Economy. The bear market in stocks, sluggish economy, terror threat, war, long decline in interest rates, and higher unemployment have impacted organizations' interest in sponsoring LTCI, elders' retirement income and savings, and the assets and profitability of insurance companies which offer LTCI.

LTCI Higher Prices, Lower Investment Earnings, and Cost Pressures. Many LTCI companies have raised premium prices on new policies to provide and pay for new features and to make up for decreases in profitability on older policies. Factors that have seriously impacted profitability are the decline in investment income due in part to the decline in interest rates, an increase in the unrealized losses from aggressive investing, small number of policy owners that have let their policies lapse, and high marketing and other costs.

LTCI Affordability, Suitability, and the Cost of Delaying Making Decisions. In today's economic environment, the priority that prospective buyers can afford to give the purchase of suitable LTCI policies—reflecting choices of carrier quality and levels of coverage—most likely calls for difficult decisions requiring a lot of thought. Among the points to be weighed: given their circumstances, can they afford to be without appropriate coverage, especially if purchased at younger ages at lower premium prices. Affordability is an issue not only for individuals but also for all levels of governments. (**STRATEGY: LTCI may be financed by selling investments, selling a home, or by family members. Consider if an individual can afford LTCI and has: over $40,000—preferably $50,000 of income, over $200,000 of liquid investment assets, and whether a $100 daily benefit minimum level of coverage and premiums would be lower than 10% of pretax income.)**

Health and Long-Term Care Cost Population Impact. Health, Medicare, Medicaid, and prescription costs have been increasing at more than double the rate of the Consumer Price Index, as attempts to contain them have failed. With an older population, the outlook is for federal and state governments' share of health costs increasing and for their having greater difficulty avoiding larger deficits. Given the expected doubling of the senior population and the quadrupling of elders over 85, who usually require a higher level of long-term care services, in the next 30 years, governments are concerned about any expansion of health and long term care service programs.

Estimated Number of Incapacitated/Incognitive Elders, and Duration. Today 7 million seniors require long-term care services. About 5.5 million of them are at home, and 1.5 million are in nursing homes, where women account for about 85% of the residents, indicating that if women continue to outlive men they will have a greater risk of requiring care. Another 7 million people, disabled but not yet 60, also require long-term care services, often for many years. LTCI services may be required for an average of 2½ years or for the following periods: under 90 days, 26%; 91 days to one year, 19%; one to five years, 34%, and over five years, 21%. (**STRATEGY: Recognize LTCI coverage must be flexible with women outliving men, and many more elders having non-traditional relationships.)**

Growing Caregiver Shortage Impacts Costs. The shortage of care providers in hospitals, nursing homes, senior housing, and elders' own homes is increasing. With the caregiver population aging and underpaid, other better and higher-paid jobs available, and limiting of immigrants, the shortage of caregivers will increase significantly. Caregivers will have to be paid overdue higher wages to attract and keep them as indicated in Chart 1 on care costs.

The Premature Senior Housing Boom of the 1990s and Nursing Current Doldrums. Low occupancy and high costs of assisted living facilities, built mostly in the 1990s well in excess of demand, have led to numerous industry bankruptcies. With about half its revenues coming from Medicaid, that program's problems place the nursing home industry at risk. It's also facing other revenue problems, as well as cost problems, at the same time: declining occupancy, pressure for wage increases, and demands for better service, which implies increasing staff levels.

Chart 1
Projected Costs for 4 Care Plans in New York City Area

Daily & Annual Care Costs for Home, ALF, CCRC, and Nursing Home Care Plans

	Current and Projected Costs		
	2003	**2018**	**2033**
Home & Live-In Care	$200/$73,000	$400/$146,000	$800/$292,000
Home 2 Shifts Care	$312/$113,800	$624/$227,600	$1,248/$455,520
ALFs/CCRCs	$120/$43,800	$240/$87,600	$480/$175,200
Nursing Home	$270/$98,550	$540/$197,100	$1,080/$394,200

Disability Income Impact on Needed LTCI Policy Improvements. In the late 1980s, life insurance companies' disability income (DI) policy claims increased from experience in prior years by about 30% as did the duration of claims. After having sold its DI business, John Hancock has limited its LTCI coverage flexibility. Other insurance companies that continued to offer DI coverage tightened underwriting and reduced offerings of non-cancelable price-guaranteed policies in addition to increasing prices. As companies remember bankruptcies resulting from DI claims' costs, they are reluctant to improve LTCI coverage. Companies incorrectly compare these two quite different types of policies and forget to consider the LTCI benefit triggers and the duration of these claims at older ages, which are much shorter than DI ones at younger ages.

High Care Costs and LTCI Benefits

The costs of hiring long-term care custodial caregivers vary with care arrangements and location. Chart 1 summarizes representative current/projected costs for four different care plans in the New York City area, assuming 5% CAGR uncapped inflation rider that is the same as reflected in Chart 2.

With the shortage of underpaid caregivers, custodial caregiver costs are expected to increase faster than the Consumer Price Index (CPI) and to grow 5% annually and to double in 15 years by 2018 and double again by 2033. The levels of annual LTCI coverage that may be adequate are indicated below. Care costs may exceed $500,000 for a few or more years of care.

The favorable benefit divided by total cost ratios evidence LTCI's value. Premium costs until after age 70 appear reasonably low, and often may be affordable. However, the plans in Chart 2 only cover a first-year $100 daily ($36,500 annual) benefit, for three years of coverage, and a 5% CAGR inflation rider or level (L) at age 80, and exclude any premium discounts or any not probable premium increase. Thus LTC costs may either be self-financed, or to cover a higher level of coverage or more years of coverage will double or triple premium costs. (**STRATEGY: Purchasing coverage at younger ages to avoid the high cost of waiting when premiums are affordable and taking advantages of favorable discounts, may be the best way to finance LTC costs.)**

Chart 2
LTCI Premium Costs Compared with Benefits

Starting Age	Annual Premium(a) to 85(b)	# Years	Total (aXb) Premiums	Total 3-Year Benefits(c)	Favorable Benefit/Costs Ratio - c/(aXb)
Age 50	$1,039	35	$36,365	$603,000	16.6X
Age 60	$1,595	25	$39,875	$372,000	9.3X
Age 70	$3,333	15	$49,995	$228,000	4.6X
Age 80	$6,960	5	$34,750	$141,000	4.1X
Age 80 L	$5,989	5	$29,945	$108,000	3.6X

Changes Among the LTCI Companies

Among the major factors contributing to the leading LTCI companies' revenue growth and underlying LTCI issues and concerns which are likely to remain important:

Acquisitions. GE acquired AMEX and Travelers, John Hancock acquired Time Fortis, Conseco acquired American Travelers and Bankers Life and Casualty, and AEGON acquired Monumental and Transamerica. The lower prices and possibly less stringent underwriting of acquired companies' policies may cause acquirers to seek approvals from state insurance departments for in-force policy price increases.

Fewer Competitors and 2 Bankruptcies. Some companies have discontinued LTCI coverage, including AIG, AFLAC, Gerber, Principal Life, and John Alden. Two of the largest LTCI carriers became bankrupt in 2001. Conseco's bankruptcy is attributed mostly to its acquisition of a mobile home financing company. Penn Treaty, a specialized one product aggressive LTCI company, attempted to grow the business without adequate capital—perhaps by being too lenient in its underwriting practices. New York State gave both companies permission to increase premium prices over 40% to enable them to continue servicing policies.

Improvements in In-Force Coverage. Some older policies received a retroactive upgrade to cover state-licensed assisted living facilities and depression, which had not been included in most older policies.

Reinsurance. LTCI issuers often reinsure LTCI with its required insurance high risk based capital. The companies are likely to encounter high reinsurance costs and more stringent requirements imposed by reinsurers, trends that could impair future innovation and improvement in LTCI policy design.

CNA's Marketing Uncertainty. Primarily a property and casualty insurance company, CNA withdrew its old LTCI policies for individuals and associations, relinquishing its former leadership position until its new product line is approved and can be successfully launched.

UNUMProvident and LTCI Pricing, Created by a 1999 merger of three of the largest DI companies, UNUMProvident has been defending itself against a growing number of publicized class action suits for its DI claim handling practices. Since these events started last fall, its ratings have been downgraded and a CEO fired. In May 2003, it raised about $1 billion of new common stock and convertible debenture capital, and centralized its retail DI and LTCI sales support.

Of particular concern to current and prospective UNUMProvident LTCI policyholders were plans announced in February 2003 to raise prices on LTCI policies in force. Shortly thereafter these plans were withdrawn, presumably because of the publicity generated by the class action suits and customer reaction. Policy owners can not rule out a submission to a state department of insurance to increase prices on older underpriced policies. Like other LTCI companies, UNUMProvident has announced plans for an overdue higher priced new policy to be marketed at 50% to 60% higher prices after approval by a state.

Current Home Care Coverage Limitations and Need for Flexibility

In the 1970s until the 1980s, most companies only reimbursed licensed nursing home care. Starting in the late 1980s, nursing home care and home care coverage have been usually combined into a single integrated policy. In conformity with the nursing home skilled care model, most LTCI companies only reimburse home care coverage provided by licensed home care agency caregivers or directly hired certified home caregivers.

Home Care "Real" Costs. The belief that home care is cheaper than nursing home care is a myth that has helped prolong today's reimbursement home care policies. If costs associated with living at home are added to one or two shifts of care, home care is usually more costly than living in a nursing home, especially for a single person.

Home Care Agencies. Today licensed home care agencies usually only compensate their home caregivers little more than the minimum wage—$6 to $7 hourly—provide few, if any, benefits and, thus, do not attract and keep the best caregivers. Agencies usually charge for their services on an hourly basis. Excluding an LTCI company discount arrangement, agencies today advertise the following high fees for home health aides nationally: $17 hourly, $408 daily, or $148,920 annually. Of course, the above outlays may be reduced if fewer hours of care suffice or rates are lower. This may depend on the availability of family, neighbors, or an individual not requiring 24 hour care.

Home Care LTCI Coverage. Home care reimbursement provisions in most policies are not sufficiently flexible to meet the preference of most seniors to hire private caregivers and to cope with the growing shortage of caregivers, and expected higher costs. Although home care is the main concern of seniors, it is misunderstood, largely because it is confusingly presented by companies and sales agents. About 80% of elders requiring long-term care services reside at home or in assisted living facilities or CCRCs.

Many policy owners with older home care coverage policies do not understand that reimbursement of LTCI costs under their policies has been limited to care obtained through agencies, which supply about 10% of home caregivers in the U.S. Newer policies permit the insured to employ certified home health aides, but policy owners usually do not understand how home aides are certified, recruited, and trained—and that the supply is not equal to the demand. (**STRATEGY: A few A or better A.M. Best rated companies in Chart 3 have plans that pay the full cash benefit outright for any purpose. These policies are most flexible and more costly in line with paying usually higher claim payments. Cash policies are needed to hire a private caregiver, share benefits with a spouse, significant other partner, friend, nontraditional relationship, or pay for congregate care.)**

Home Care Features. LTCI companies also have added appealing new features, integrated at no cost in a policy or priced separately as a rider. Home care coverage related features have been gradually improved in LTCI policies which offer limited care management consultation, care training for caregivers and family members, respite care for an insured to relieve a caregiver, reimbursement of adult day care programs, some homemaker services, and even (in some policies) home medical equipment not paid by Medicare or minor home improvements. However, with the probable cutbacks in government and even private programs, it is a major concern that we do not have programs to deal with future elder care needs—including how to staff and finance them.

Many home caregivers prefer to be hired directly, thereby being better compensated, and having more flexible work schedules. However, actuaries and LTCI companies are understandably reluctant to offer more generous coverage that increases claim payments. Consumer interest in greater home care flexibility may encourage at least some companies to offer more valuable, better coverage and encourage consumers to purchase their LTCI policies. (**STRATEGY: Select a company that permits an insured at home to hire private caregivers or offers a cash benefit policy to have more flexible home care coverage.)**

Ratings, Guaranteed Renewable Policies and Prices, and National Association of Insurance Commissioners (NAIC)

LTCI coverage is offered by about 100 insurance companies in the U.S. Less than 20% of these may be acceptably rated; that is, assigned one of the top three ratings A++, A+, or A by A. M. Best, the most widely followed ratings firm for the insurance industry. The ratings of the companies' equity and bond issues, issued by Moody's and Standard & Poor's, also warrant a look, as do the most recent industry and company reports that these rating agencies may have published (See Chart 3). **(STRATEGY: Exercise ongoing due diligence in considering and reviewing LTCI company ratings.)**

State insurance departments require standard coverage terms and approve LTCI policies issued in each state, and they can grant or deny rate increases on in-force and new policies. While there may be a need to increase premium prices on older policies, stronger companies may refrain, increasing premium prices only on new policies. Should an insurance company become bankrupt, a state insurance department may try to help arrange the sale of the company and policies in-force, and then permit the acquiring

Chart 3
Ratings 6/2003 NY Larger LTCI Companies Permitting Hiring a Private Caregiver & A.M. Best Ratings A or Better (# from Top)

Companies	Best	Moody's	S&P	Remark
GE	A+(2)	Aa2(3)	AA(3)	
Met Life	A+(2)	Aa2(3)	AA(3)	
Prudential	A(3)	A1(5)	A+(5)	
Mass Mutual	A++(1)	Aa1(2)	AAA(1)	

company a large premium increase to maintain coverage funding.

The NAIC has developed and proposed model regulations for every state to adopt to establish standard coverage requirements and terms as well as to minimize in-force premium price increases and thus protect policy owners. The NAIC also has developed affordability and suitability requirements, but these are merely recommendations without sanctions for violations. A recent NAIC LTCI model regulation requires an LTCI company's actuaries to certify that proposed premiums on new policies are adequate and may be maintained for the life of a policy to help stabilize future in-force LTCI premium prices.

Underwriting, Benefit Triggers, and Claims

Most companies have gradually tightened underwriting guidelines, especially in the past year, as they focus more on medical conditions that may lead to years of incapacity such as diabetes and strokes. LTCI companies may offer an applicant a preferred health discount as long as an applicant is a nonsmoker and has had no serious health problems. On the other hand, individuals with health problems may be given a lower rating and required to pay a higher premium or be declined coverage if they suffer from congestive heart disease, Parkinson's, MS, emphysema, rheumatoid arthritis, severe osteoporosis, or other serious health history risk.

The 1996 federal Health Insurance Portability and Accountability Act (HIPAA) covers all tax qualified LTCI policies that have the two standard benefit triggers for an insured to qualify for benefits: 1) being incapacitated and having serious problems in performing two of six basic activities of daily living (ADLs) starting with bathing, dressing, transferring from a bed, toileting, feeding, and incontinence or 2) being seriously incognitive impaired, such as a person diagnosed with dementia, Alzheimer's disease, or strokes. While elders usually require the services of skilled medical personnel to diagnose and treat serious health conditions for which they are partially reimbursed by Medicare, they also have to pay personally for custodial care—often full-time, when suffering chronic health and aging problems—in order to function and to minimize risk and injury. (**STRATEGY: Contact a doctor to appeal an underwriting decline or before submitting a claim.)**

According to HIPAA, for a tax qualified plan's benefits to be tax favored, a claim must be diagnosed as chronic. Thus a hip replacement operation from which a quick recovery is expected is usually not accepted as a claim. An applicant must require care for over 90 days.

Selecting a Policy and the Relative Value of Specific Coverage and Features

When considering an LTCI policy and its specific configuration to determine what would be most suitable for a buyer, it is important to review the coverage in comparable specimen policies of a few recommended leading companies with an independent LTCI broker specialist. (Inasmuch as insurance companies adopt many of the terms they use in writing their policies from federal and state laws and regulations with which they must comply, their terminology tends to be standardized. Policies usually provide definitions of the more widely used terms. Owing to space limitations, they are not repeated here.)

Given the importance of avoiding any erroneous and costly assumption, miscalculation, or ambiguity to ensure that expectations of future costs and benefits are realistic, it is imperative that brokers know fully what they are selling and share their knowledge forthrightly with clients. The stakes are too high for salespeople's simplistic presentations or for purchasers' preconceived notions of likely cost, benefit triggers, and benefit amounts—not to mention their reluctance to deal with the possibility that they may be incapacitated and in need of help one day.

To reduce confusion about policies and facilitate understanding of LTCI, some of the more common policy facets are summarized below by a more meaningful grouping of types of coverage:

A) **Substantive Policy Selection Criteria**: 1) LTCI company rating; capability, and commitment; 2) Home care coverage flexibility; 3) Premium pricing determinants, which vary by company and policy configurations but usually include an applicant's age, health, level of coverage selected, inflation rider, years of benefits provided for, length of waiting period before benefits are paid, opportunities available for discounts (spousal, preferred, and group), and features or condition calling for higher prices; 4) Reasons for underwriters approving or declining an applicant; 5) Broker's independence and specialized service commitment.

B) **Extra Features to Consider at Possibly Higher Premium Price**: 1) Inflation rider (a 5% CAGR

inflation rider is usually recommended unless a person is about 80 or older), 2) Fewer days to wait before benefits are paid, 3) Restoration rider, and/or 4) Survivorship benefit, which provides for waiver of a surviving spouse's premium payments under certain conditions.

C) **High Priced or Questionable Features**: 1) Non-forfeiture rider required to be offered but not purchased, 2) Shared spousal benefit, 3) Abbreviated funding (not lifetime) of coverage, 4) A level benefit with an option to buy additional coverage periodically if electing to avoid the extra cost of a 5% inflation rider, a purchaser probably will have to absorb an even higher premium cost when he or she purchases modest additional coverage in his or her old age and faces higher inflation risk, making coverage too costly.

D) **Standard Policy Coverage at No Extra Cost**: 1) Mostly HIPAA standardized benefit triggers, 2) Coverage at home, nursing home, state licensed assisted living facility whose cost is reimbursed if an insured meets benefit triggers, respite care, nursing home, alternative care, 3) Other provisions: waiver of premium payments, company guaranteed renewability, hospitalization not required before paying a benefit, Medicare benefits paid before LTCI with benefit coordination, free look period, lapse reinstatement, and limited care planning assistance.

E) **Exclusions in Most Policies**: 1) Care described as informal provided by a family member except as offered in a few, most flexible cash benefit policies, 2) Care outside of U.S., 3) charges reimbursed by Medicare, 4) War or self-inflicted injuries.

Tax-Qualified Policies for Individuals

The HIPAA and IRS regulations provide two types of tax advantages, under certain circumstances, for "tax qualified" policies: tax-free benefits and deductible premiums.

How much of eligible premium deductions may be deducted from taxable income, depends on the total of deductible medical expenses, adjusted gross income for the year, and maximum allowable deduction assigned to a person's age group at the end of the tax year. For 2003, they were by age groups: 40 or younger = $250, 41 to 50 = $470, 51 to 60 = $940, 61 to 70 = $2,510, or 71 or older = $ 3,130.

In accordance with IRS regulations, individuals can add LTCI premiums up to the maximum for their age bracket when totaling all of their deductible medical expenses. Depending on by how much their total medical expenses—including the LTCI premiums—exceed 7.5% of their adjusted gross, they may be able to deduct all or some of their LTCI premiums; usually, however, they can deduct little if anything unless a person is old, poor, or has truly sizeable medical expenditures.

LTCI Strategies and Issues

The following are a few important strategies and reasons to select appropriate LTCI coverage:

- Buy time to protect assets (not income) with a competitively priced NY Partnership policy in order to be able to protect assets (not income) from Medicaid recoupment and have guaranteed access to a nursing home after a policy's benefit is used.
- Purchase less than full coverage and self-insure some risk.

To develop rational long-term care plans and consider LTCI coverage choices, consumers and their advisors need to take into consideration the following points to be prudent:

- Focus especially on home care provisions when reviewing the coverage of policies.
- Most policies currently in force or sold may not meet the full expectations of buyers so that it is important to reevaluate policies in force as well as new ones.
- Given the differences among LTCI policies, it is important to compare the coverage provided by several to identify the one most suitable.
- A few large, higher rated companies are committed to improving their current policies and should grow and gain larger, viable market shares.

In summary, most individuals expect to live many years but do not develop adequate plans to provide for a comfortable retirement, including long-term care that may become necessary. Given the likelihood of incurring the high and steadily higher cost of long-term care services, whether a person remains at home or moves to an ALF, a CCRC, or nursing home, it is imperative to consider flexible LTCI, by a strong company, if coverage is affordable, suitable, and a person insurable.

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Al is active in the NYC & Westchester Estate Planning Councils, Financial Executives Institute and Chairs NY Chapter Retiree Planning Roundtable, WEB, Planned Giving Group NY, the Financial Planning Assoc., Advisor for Health Advocates for Older People and Carnegie East enriched housing, and previously National Aging Council, and on Westchester Alzheimer's Assoc. Board.

Al regularly speaks at meetings/conferences for CPAs, trust departments, estate planning councils, NY/GHV Financial Planning Associations, and elder organizations; and chaired a group LTCI conference. He has written articles for the *FPA NY Planner, CT Community Care Lines*, and has been quoted in *Investors Chronicle, Practical Accountant, Accounting Today*, and *Bloomberg Wealth Manager*; has been a speaker on CNN, Time Warner TV; and WGBB "Money Talk," "How Charities Make a Difference," and WPAT "Senior Advisor." Al participates in NYC/Westchester professional organizations and in financial, legal, caregiver, Medicare, and senior center programs.

FSS publishes the "Serving Senior Financial Needs" newsletter. Al has authored a lead article entitled "Surviving Future Elder Care Costs" for the *CPA Journal*, and is publishing a new *Journal* article on the outlook for LTCI. His chapter on "Group LTCI: An Employer/Employee Benefit," published by Panel Publishing, is being revised. In 1995, he co-authored a Harcourt Brace monograph, "Planning for the Elderly." His study, "Elder Financial Planning Long Term Care Financing Strategies," was presented at the January 1996 Personal Financial Planning Conference, and an April 1996 article on LTCI for *Trusts & Estates*. He has authored two articles for the NYSBA Elder Law Section newsletter on the 1996 HIPAA Act and Elder Financial Planning Strategies.

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What Every New York Elder Law Attorney Needs to Know About a Medicaid Qualified Annuity

By Dale M. Krause, J.D., LL.M., CEPS

With the state of New York being divided into two geographical regions, namely, the New York City metropolitan area and upstate New York, and with these regions containing 674 nursing homes,[1] and further being ranked #2 and #4 in the United States regarding the highest nursing home costs,[2] it should not be a surprise to know that when families are faced with a loved one entering a nursing home, for purposes of a long-term stay,[3] they are thrust into a world of financial despair, causing questions to arise such as:

- How can Mom afford to stay?
- How long will $150,000 last?
- Should we take Dad home?
- What happens when Mom runs out of money?
- What about Dad's estate plan?
- How does the prenuptial agreement change things?

With the advent of elder law, which has culminated into a legal specialty over the last 16 years,[4] a family can now find comfort in working with an elder law attorney who specializes in nursing home planning.[5] This type of practitioner has been referred to as a "Crisis Medicaid Planner."[6]

How does an elder law attorney solve such a financial crisis? The elder law attorney solves the financial dilemma by qualifying the nursing home resident for New York Medicaid benefits.

In order to immediately qualify a nursing home resident for New York Medicaid benefits, in addition to the usual requirements,[7] the elder law attorney will facilitate a plan which will allow the nursing home resident to meet the strict income and resource requirements of the New York Medicaid program. To satisfy the income requirement of the New York Medicaid program, the nursing home resident must be able to show that his or her current monthly income is less than the facility's monthly private pay rate.[8] With the exception of only a small number of nursing home residents,[9] the typical nursing home resident is able to satisfy the income test, without any planning, in that his or her monthly income includes only that from social security,[10] and possibly a pension. As such, the more important test relates to the resource requirement. In order to satisfy the resource requirement, the nursing home resident must be able to show that his or her countable resources[11] are valued at $3,850 or less. Again, with the exception of only a small number of nursing home residents, the typical nursing home resident is unable to satisfy the resource test, without additional planning, in that his or her cash and other countable resources usually exceed $3,850 in value.

"With the advent of elder law, which has culminated into a legal specialty over the last 16 years, a family can now find comfort in working with an elder law attorney who specializes in nursing home planning."

In those cases where the nursing home resident has excess countable resources, before the nursing home resident can be eligible for New York Medicaid benefits, the nursing home resident must spend down the excess amount. For those nursing home residents who are without the benefit of an elder law attorney, this typically means that the excess amount will be spent on the nursing home.[12] In such a case, with the average monthly cost being $8,187,[13] it does not take but a short time to spend down the excess amount.

Is there a better economic result? Absolutely! With the services provided by an elder law attorney, the spend-down amount will be first applied to improving the nursing home resident's quality of life, including: the purchase of clothing, certain furniture items, and personal supplies. Next, the elder law

attorney will recommend that the nursing home resident pre-pay his or her funeral plan.[14] Finally, with respect to the remaining spend-down amount, the elder law attorney may recommend that the nursing home resident purchase a Medicaid Qualified Annuity.[15]

What is a Medicaid Qualified Annuity? It is a Medicaid planning tool offered by a limited number of insurance companies. The Medicaid Qualified Annuity was designed to convert the remaining spend-down amount into a stream of income. Following the conversion, with the spend-down amount totally eliminated, the nursing home resident then becomes eligible for New York Medicaid benefits.

What are the requirements for establishing a Medicaid Qualified Annuity under New York's Medicaid program? With New York's Medicaid program following the requirements of HCFA Transmittal 64,[16] which transmittal outlines the requirements for establishing a Medicaid Qualified Annuity, a Medicaid Qualified Annuity is properly structured when the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the investor/annuitant/beneficiary.[17] At the same time, under HCFA Transmittal 64, when a Medicaid Qualified Annuity is properly structured, it is referred to as "actuarially sound."

Additionally, with HCFA Transmittal 64 not requiring a specific mode of payment,[18] nor a required rate of return,[19] but only regular payments of income, different types of Medicaid Qualified Annuities developed, including: a Lump-Sum Balloon Style Medicaid Qualified Annuity,[20] a Level Monthly Payout Medicaid Qualified Annuity,[21] and an Annual Payout Medicaid Qualified Annuity.[22]

To illustrate the use of a Lump-Sum Balloon Style Medicaid Qualified Annuity under New York's Medicaid program, please consider the following facts:

Assume that Mrs. Smith, an 85-year-old widow, is a resident of a New York nursing home. After privately paying for June and July of 2003 at an all-inclusive rate of $9,000 per month, Mrs. Smith's family is concerned that their mother's remaining life savings of $130,000 is not going to last very long. After meeting with a New York elder law attorney, Mrs. Smith's family understood that without any additional planning, their mother's life savings will last approximately 14 months.[23]

After receiving the elder law attorney's advice, and after purchasing some personal items and a prepaid funeral plan, and paying the nursing home for August of 2003, Mrs. Smith utilized the remaining spend-down amount by purchasing a $100,000 Lump-Sum Balloon Style Medicaid Qualified Annuity. The Medicaid Qualified Annuity will provide the following guaranteed monthly payments to Mrs. Smith:

Months 1–78:	$254
Month 79:	$99,464
Total Payout:	**$119,276**

With Mrs. Smith having a 6.63-year/79.56-month Medicaid life expectancy, and with her Lump-Sum Balloon Style Medicaid Qualified Annuity returning at least $100,000 to her within her Medicaid life expectancy, the Lump-Sum Balloon Style Medicaid Qualified Annuity is properly structured, "actuarially sound," and a viable Medicaid planning tool.

"[I]n light of the economic results that can be obtained from using a Lump-Sum Balloon Style Medicaid Qualified Annuity, it is easy to understand how the Medicaid Qualified Annuity has become a premier Medicaid planning tool in the state of New York."

With the Lump-Sum Balloon Style Medicaid Qualified Annuity in place in August of 2003, Mrs. Smith is eligible for New York Medicaid benefits as of September 1, 2003. On the assumption that Mrs. Smith has $500 of monthly social security income, her monthly co-pay to the nursing home would be $704[24] in September of 2003, and each month thereafter.

With the nursing home charging $9,000 per month, by qualifying for New York Medicaid benefits as of September 1, 2003, Mrs. Smith effectively reduced her monthly out-of-pocket nursing home expenses by $8,296.

In closing, in light of the economic results that can be obtained from using a Lump-Sum Balloon Style Medicaid Qualified Annuity, it is easy to understand how the Medicaid Qualified Annuity has become a premier Medicaid planning tool in the state of New York.

Endnotes

1. This information was reported by the Centers for Medicare and Medicaid Services, and can be found at http://www.medicare.gov. Additionally, it has been reported by the New York State Department of Health that there are approximately 117,000 people residing in nursing homes in the state of New York; this information was obtained from http://www.health.state.ny.us/nysdoh/nursing/main.htm.
2. This information was obtained from http://www.efmoody.com/ongterm/nursingstatistics.html. Additionally, at page 16 of 20, it was stated that the New York City metropolitan area had an average annual nursing home cost of $106,500, while those areas located outside of the New York metropolitan area had an average annual nursing home cost of $90,000.
3. A long-term stay is generally defined as a "stay that exceeds 100 nursing home bed days." Additionally, please be advised that under the Medicare Program, Medicare will pay for a maximum of 100 days of skilled nursing home care, following a hospitalization of at least three full days. To qualify, the patient must be admitted to the nursing home within 30 days of the discharge from the hospital. For 2003, Medicare pays the entire bill for the first 20 days, and all but the first $105 per day, for days 21 through 100.
4. The National Academy of Elder Law Attorneys ("NAELA"), Inc., located in Tucson, Ariz., which is a non-profit organization, was established in 1987, in order to assist lawyers, bar organizations, and others, who work with older clients and their families. The mission of NAELA is to establish NAELA members as the premier providers of legal advocacy, guidance, and services, to enhance the lives of people as they age. For more information on NAELA, please consult their Web site which is located at http://www.naela.org.
5. The New York State Bar Association has an Elder Law Section. For information on the Elder Law Section, please consult their Web site which is located at http://www.nysba.org/elder.
6. Crisis Medicaid planning generally takes place when an individual meets all of the following criteria:
   (a) is confined to a nursing home,
   (b) is not expected to return home or into the community,
   (c) has longevity—not on his or her immediate death bed,
   (d) exhausted all of his or her Medicare and Medicare supplemental insurance benefits, and
   (e) has been asked to self-pay.
7. Generally, the nursing home resident must be 65 years of age or older, a resident of the state of New York, and a citizen of the United States.
8. According to the article entitled, "Nursing Home Costs Show Need for Long-term Care Insurance, Says Survey," written by Vicki Lankarg of Insure.com, the average daily cost of a nursing home stay in the state of New York is $246. When this amount is multiplied times 365 days, and then divided by 12 months, the net result equals $7,482. To review this article in more detail, please consult the following Web site: http://info.insure.com/ltc/nursinghomecosts302.html.
9. In very few cases, a nursing home resident may be the beneficiary of a previously purchased nursing home insurance plan. With the monthly benefits from the nursing home insurance plan, which are deemed income under the New York Medicaid program, the nursing home resident may find that his or her total monthly income, from all sources, including that from social security and pension, exceeds the respective facility's monthly private pay rate. With this result in mind, the nursing home resident is ineligible for New York Medicaid benefits.
10. According to Social Security's Internet Web site, which is located at http://www.socialsecurity.gov, the average 2003 monthly social security benefit for a retired worker is $895, a retired couple is $1,483, and a widow(er) is $862.
11. Under New York's Medicaid program, a nursing home resident's resources are deemed either "non-countable" or "countable." For the typical nursing home resident, his or her non-countable resources generally include: clothing, limited furniture, a pre-paid funeral plan, and possibly an automobile. Additionally, for the typical nursing home resident, his or her countable resources generally include: cash, savings account, checking account, certificates of deposit, savings bonds, and cash value life insurance with a face value of more than $1,500.
12. A nursing home resident will incur three separate charges from a nursing home, including: (1) room and board, (2) pharmacy, and (3) incidentals.
13. This amount was determined by adding together those amounts reflected in note 2 of this article *supra*, and dividing by two, and further dividing by 12 months.
14. Under New York's Medicaid program, a nursing home resident is allowed to pre-pay his or her funeral plan. It is typically accomplished by having the nursing home resident establish an irrevocable pre-need trust, and funding it accordingly, so that the irrevocable pre-need trust covers all specific goods and services related to the funeral plan, including a burial space.
15. Under New York's Medicaid program, particularly the New York State Department of Social Services Administrative Directive: 96 ADM-8, which directive regulates Medicaid Qualified Annuities, an annuity is an investment vehicle whereby an individual establishes a right to receive fixed periodic payments, either for life or a term of years. To the extent that the anticipated return is commensurate with the money invested, it is treated as a compensated transfer of assets; to the extent that the anticipated return is less than the amount invested, it is considered a trust-related transfer for less than fair market value.
16. In November of 1994, the Secretary of Health and Human Services issued HCFA Transmittal No. 64, which specifically authorized the purchase of an annuity, provided the annuity is actuarially sound. The actuarially sound test is satisfied if the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the investor/annuitant/beneficiary. If it satisfies the actuarially sound test, the annuity is a viable Medicaid planning tool. If it does not satisfy the actuarially sound test, the annuity will be treated as an uncompensated transfer, and may be subject to a divestment penalty period.
17. To determine an investor/annuitant/beneficiary's reasonable estimate of life expectancy, please consult the age and gender based life expectancy tables, which are part of Transmittal No. 64.
18. The specific mode of payment includes: monthly, quarterly, semi-annual, and annual.
19. If a specific rate of return is not required, as long as the nursing home resident receives back all of his or her investment over his or her Medicaid lifetime, the Medicaid Qualified

Annuity is deemed actuarially sound. Some states, like Idaho and Wisconsin, have a required rate of return test, in addition to the actuarially sound test.

20. The Lump-Sum Balloon Style Medicaid Qualified Annuity was designed to pay very small monthly payments throughout the term of the Medicaid Qualified Annuity, with the exception of the last month, which is the balloon payment. Additionally, the Lump-Sum Balloon Style Medicaid Annuity is generally used in a Medicaid case involving an individual, with no community spouse.

21. The Level Monthly Payout Medicaid Qualified Annuity was designed to make equal monthly payments throughout the term of the Medicaid Qualified Annuity. Additionally, the Level Monthly Payout Medicaid Qualified Annuity is generally used in a Medicaid case involving a community spouse. However, in those states, which do not allow an individual to utilize a Lump-Sum Balloon Style Medicaid Qualified Annuity, but instead have a level monthly payout requirement, the Level Monthly Payout Medicaid Qualified Annuity is the product of choice.

22. The Level Annual Payout Medicaid Qualified Annuity was designed to make equal annual payments throughout the term of the Medicaid Qualified Annuity. Additionally, the Level Annual Payout Medicaid Qualified Annuity is generally used in a Medicaid case involving a community spouse. However, in those states, which do not allow an individual to utilize a Lump-Sum Balloon Style Medicaid Qualified Annuity, but instead have a level payout requirement, the Level Annual Payout Medicaid Qualified Annuity is the product of choice.

23. This amount was determined by dividing $100,000 by $9,000 per month, for a net result of 11.11 months.

24. This amount was determined by totaling Mrs. Smith's monthly income, and reducing it by her $50 monthly personal needs benefit. Additionally, in the event that Mrs. Smith pays for a Medicare supplemental insurance plan, the amount shown, is reduced dollar for dollar, by the monthly cost of the plan.

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For the last 17 years, Mr. Krause has been working with elder law attorneys throughout the United States, to service their clients' medicaid planning needs, with an emphasis on immediately qualifying someone for Medicaid benefits through the use of a Medicaid Qualified Annuity.

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Taking Advantage of Low Interest Rates in Planning Lifetime Family Wealth Transfers

By Mike Rosenberg, CPA, MBA

The decline in asset values, coupled with a low-interest-rate environment (while it lasts), offer some interesting opportunities for lifetime transfers of assets at little or no transfer tax cost. These opportunities are further enhanced when combined with entity-based valuation discounts applicable to transfers of ownership interests that lack voting control and marketability.

Family wealth planning continues to be important despite some congressional attempts to permanently repeal the estate tax. Although the House of Representatives recently passed a bill that would make the 2010 estate tax repeal permanent, there is not sufficient support in the Senate to go along with permanent repeal. Even if the estate tax is repealed, lifetime gifts will continue to be subject to gift tax for gifts in excess of the $1 million lifetime exemption. Hence, structuring tax-efficient lifetime transfers of family-owned business interests (such as family partnerships and S corporations), will continue to challenge us into the foreseeable future.

Lower interest rates have not only encouraged mortgage refinancing and other commercial borrowing, but have also dictated lower IRS monthly published interest rates that must be charged on intra-family loans and installment sale notes, as well as specific rates that must be used in combination with mortality factors to determine the value of life estates, term interests, annuities and remainder interests in property. These low rates facilitate use of certain estate planning techniques that exploit the difference between the assumed rate of return on an investment under transfer tax law and the actual rate of return that can be achieved for the investment. Carefully structured transactions that exploit such interest rate arbitrage permit shifting wealth between generations in a tax-efficient manner.

Lending money at low rates to family members to purchase ownership in business interests and other investments can be attractive. To avoid gift tax, the interest rate needs to be no less than the applicable federal rate mandated on a monthly basis by the IRS. The rate applicable to a demand loan made in August 2003 is 1.21%. If the loan is structured with a term of five years, the rate is fixed at 2.7%. A term greater than nine years requires a fixed rate of 4.36%.

An intra-family loan also offers greater flexibility than commercial loans in structuring payment terms that fit the specific needs and resources of the borrower. Balloon notes that provide only for the payment of interest will enhance the borrower's liquidity. A $500,000 loan structured as a 20-year promissory note with a single principal balloon payment at the end, will require a minimum rate of 4.36%, or annual interest of $21,800.

"Family wealth planning continues to be important despite some congressional attempts to permanently repeal the estate tax."

The lender may decide on a year-by-year basis whether to forgive or collect the interest, depending on cash needs. If annual interest is forgiven in a particular year, the amount will be less than the $22,000 combined annual gift exclusion, available to spouses electing gift splitting. Although the lender is required to report the forgiven interest as income for income tax purposes, the forgiven interest will not result in a taxable gift since it is within the annual gift exclusion. Of course, intra-family loans should not be created with the implied or express understanding that the loan will be forgiven over time, otherwise, there is the risk that the IRS will treat the entire amount loaned as a gift from inception, which can have unintended gift and estate tax implications.

Low interest rates also benefit intra-family installment sales. Such sales shift wealth when the growth rates of the assets sold exceed the applicable federal rate required on the note. An asset valued at $1,000,000 that is sold in August 2003, for a 20-year balloon installment note, will require a minimum interest rate of 4.17%. The buyer will pay $41,700 in annual interest and will benefit from asset growth and retained cash flow. If the asset grows at an aver-

age rate of 8% per annum (cash flow plus appreciation), the purchaser will have, after 20 years, an asset worth $2,750,000, with a net equity of $1,750,000. Should the asset appreciate at an annual rate of 10%, the value of the asset after 20 years will be $4,440,000, netting the buyer equity of $3,440,000.

The installment note described above can be structured at even lower interest rates if the buyer and seller are willing to adjust the interest rates on a periodic basis. For example, if the note is structured so that in the course of its 20-year term, the interest rate adjusts every five years, the rate on the note for the first five years can be as low as 2.55%. If the parties are willing to adjust the rate every three years, the initial three-year rate can be 1.21%.

Intra-family installment sales require the seller to report interest income as well as capital gain from the sale of the asset as principal is collected. With reduced tax rates, particularly with capital gain rates reduced to 15%, a taxable sale of an asset may be an attractive proposition. The buyer's advantage of a sale over a gift is a stepped-up basis in the asset purchased. This means potentially greater depreciation deductions, where applicable, and less gain on subsequent sale of the asset.

An installment sale can also be structured with a self-cancellation installment note (or SCIN). A SCIN is a promissory note where, by its terms, the principal balance of the note is extinguished if the seller should die before the note is entirely paid off. Because the note is cancelled at death, there is nothing left to be taxed in the seller's estate. Upon cancellation of the note, any unrecognized gain on the note must be reported by the seller (or his estate). However, the tax on the gain is likely to be far less than the estate tax on the outstanding note balance.

Because of the cancellation feature of the SCIN, the transaction must be structured with a mortality risk premium, either in the form of a higher interest rate or a greater principal (face) amount of the note. For example, a seller age 60, who sells an asset in August 2003 for $1,000,000 with a 20-year balloon note structured as a SCIN, must use a rate of 5.784% to reflect the mortality risk premium in the interest rate. A "straight" note would require a minimum rate of 4.17%. If the mortality risk premium is reflected in the note's principal, the face amount of the SCIN must increase to $1,245,000.

A more sophisticated variation of the intra-family sale is a technique known as an installment sale to an intentionally "defective" trust. Typically, the senior family member sells appreciated assets to an irrevocable trust in return for a promissory note that has a low interest rate equal to the applicable federal rate. The trust has as its beneficiaries junior family members, and is structured as a grantor trust for income tax purposes. This means that the grantor is taxed on the trust's income and gets the benefit of all the deductions and credits attributable to the trust. The trust is "defective" in that the grantor is treated as the "owner" of the trust assets for income tax purposes only but not for estate tax and legal title purposes. Trust assets are excluded from the grantor's estate.

Because the grantor is considered for income tax purposes to be the owner of the assets, transactions between the grantor and the trust are ignored for income tax purposes. This means that no gain is recognized on the sale of the appreciated assets to the trust and no interest income reported.

Properly structured, a sale to a "defective" trust allows asset growth in excess of the applicable federal rate paid on the note to accumulate in the trust free of gift or estate tax. The unique structure of the trust, in and of itself, provides additional estate planning benefits. The grantor's payment of income tax on behalf of the trust will reduce the value of the grantor's estate and increase the value of trust property held for the beneficiaries. In effect, the income tax paid by the grantor on behalf of the trust constitutes a tax-free gift to the trust. The trust can be structured as a "dynasty" trust whereby the trust is drafted to last multiple generations without any estate, gift or generation-skipping transfer taxes at the death of the grantor's children or lower generations.

The trust must be carefully structured to ensure it is not under-capitalized and has sufficient lending cushion to support the valuation of the promissory note it issues for the property. The key is to ensure that the transaction is considered a true sale to the trust. At least a 10% cushion is typically recommended as a gift by the grantor to the trust to establish the requisite trust equity prior to the sale of the assets.

Another gift and estate planning technique which benefits from periods of low interest rates is a grantor retained annuity trust (or GRAT). The grantor transfers assets to a trust and retains the right to receive fixed annuity payments for a term of years. At the end of the term, the remaining trust assets are distributed to the beneficiaries (or held in further trust for their benefit). Because the grantor retains an annuity interest, it is the residual value of the assets trans-

ferred to the trust (i.e., the current value of the assets, less the present value of the retained income right) that passes to the beneficiaries as a gift. This residual value is determined based on actuarial tables and the special applicable federal rate used in discounting the grantor's retained annuity payments.

One drawback of the GRAT is that if the grantor does not survive the term of the trust, all (or part) of the trust assets will be included in the grantor's estate. In certain cases, it may be possible to eliminate this mortality risk through carefully structured transactions.

If a 60-year-old grantor funds a GRAT in August 2003 when the relevant rate is 3.2%, with $1,000,000 assets having stable annual cash flow of $60,000, and retains a $60,000 annual income right for a term of 15 years or up to date of death, whichever occurs first, he will have made a taxable gift of $375,000. If the assets appreciate at 3% per annum, the value of the trust assets at the end of the 15-year term will be $1,914,000 and will pass to the beneficiaries at no tax. (It is noteworthy that the life expectancy for a healthy 60-year-old is approximately 81 years of age, and there is better than a 65% chance to live to life expectancy).

Charitable minded individuals can also take advantage of low interest rates by integrating charitable gifts with wealth transfer planning. One such technique is the charitable lend annuity trust (or CLAT). The CLAT is a trust set up by the senior family member to pay out a fixed annuity amount to charity for a specified period of years, after which the trust terminates and its remaining assets are transferred to junior family members, as the noncharitable beneficiaries of the trust. The value of the gift to the junior family members is equal to the value of the assets transferred to the CLAT, less the present value of the annuity to charity.

For example, a charitable minded parent transfers a portfolio of securities valued at $1,000,000 to a 15-year CLAT that is required to pay out annually $40,000 to charity. At the end of that period the trust terminates, and its residual value passes to the children. If the trust is funded in August 2003, the gift value of the remainder interest to the children will be $522,000. If the portfolio is expected to appreciate, on average, 8% per annum (cash flow plus appreciation) during the 15-year term of the trust, the children could expect to receive in excess of $2,000,000 of assets at the end of the trust's term.

The grantor can also obtain a charitable income tax deduction upon formation of the CLAT if the trust is structured as a grantor trust for income tax purposes. That means that the grantor will be required to report trust income on his or her individual income tax return during the entire term of the trust. Hence, if in the above example the parent structures the CLAT as a grantor trust for income tax purposes, the CLAT technique will not only produce a discounted gift value of $522,000, but will also result in a 2003 income tax charitable deduction of $478,000. Each year, for the next 15 years, the parent will be taxed on the CLAT's taxable income.

If past economic cycles are any indication, interest rates are likely to rise in the foreseeable future. Now is an opportune time to implement interest rate sensitive strategies, which take advantage of lower rates, and allow for efficient wealth transfers.

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New York Case News

By Judith B. Raskin

Home Care Liability

Plaintiff daughter sued her incapacitated mother's caregivers and the home care agency for negligent care. Dismissed. *Jacobs v. Newton, Newton, Baker and Rockaway Home Attendant Services*, F23666 (Civ. Ct., Kings Co., July 8, 2003).

Plaintiff was the daughter and Article 81 guardian for her mother, Sarah Newton. From February 1998 to October 2001, Mrs. Newton lived with her son and daughter-in-law while Medicare and Medicaid engaged a home care agency to provide additional care. The plaintiff alleged that her brother and sister-in-law and the agency physically harmed her mother by failing to provide proper care and supervision, sufficient food, and proper medication. Other siblings testified that on several occasions they found their mother alone and that she did not appear to be eating properly. The defendants denied the allegations and argued that the plaintiff had no cause of action. Eventually Mrs. Newton's health deteriorated and she was placed in a nursing home.

The Civil Court held, *inter alia*, that it could not hold the defendants liable for breach of duty. Although plaintiff has a cause of action, and although the defendants failed to provide proper care in many respects, the plaintiff, acting pro se, did not present needed expert testimony. The expert testimony would assist the court in assessing breach of duty by clarifying issues such as Mrs. Newton's medical condition and change in condition as a result of the negligent care and the regulations and standards governing the agency.

However the court did conclude that, in this case of first impression, a vulnerable elderly parent does have standing to sue a child and paid caregivers who provide negligent care resulting in harm. The court extensively reviewed statutory and case history in concluding that a breach of duty for care is actionable if certain factors are present. Home care agencies have been held liable in New York when a home care attendant was not sufficiently attentive or present but all such cases involved traumatic injuries. In a recent Fourth Department case, *Goldberg v. Plaza Nursing Home Comp., Inc.*,[1] there was a valid cause of action for negligent care resulting in confusion, agitation and cardiac arrest. In that case, the court held that a home care agency should be held liable where it fails to prevent non-traumatic injury, which is what an agency contracts to do.

Article 81

The parties appealed from a decision without a hearing denying a request for the appointment of an Article 81 guardian. Reversed and remanded. *In re Eggleston*, 2504 (1st Dep't, March 20, 2003).

Adult Protective Services petitioned for a guardian for the AIP who faced a holdover eviction from his rental apartment. The petition stated that the AIP was chronically and severely depressed, resulting in his lack of motivation to change his circumstances and his refusal of treatment. The AIP requested counsel.

The court, without a hearing, denied the petition. DSS and the AIP both appealed.

The Appellate Division reversed and remanded the matter for a hearing, finding that the petition presented a prima facie case that required a hearing on the merits. The objective of Article 81 is to tailor the guardianship to the needs of the AIP. The hearing would be necessary for the court to determine the extent of the AIP's functional limitations due to his depression and to determine whether counsel should be appointed. Section 81.11(b) gives any party the right to "present evidence, call witnesses, cross-examine witnesses and to be represented by counsel."

The AIP appealed from a decision without a hearing denying his motion to terminate his guardianship. Reversed and remitted for a hearing. *In re Marvin W.*, 2002-07273 (2d Dep't, June 2, 2003).

An alleged incapacitated person moved to terminate his Article 81 guardianship. The Supreme Court, Rockland County, denied his motion without a hearing. He appealed.

The Appellate Division reversed and remitted the matter of the termination of the guardianship to the Supreme Court for a hearing. Section 81.36 requires a hearing on a motion to terminate a guardianship. The person objecting to the termination has the burden of presenting clear and convincing evidence as to why the guardianship should not be terminated.

Nursing Home Reimbursement

Nursing home appealed Medicaid's determination that therapy was not restorative. Appeal denied. *Elcor Health Services, Inc. v. Novello*, 85 (Ct. of Appeals, June 26, 2003).

The appellant nursing home classified the therapy received by 29 of its residents as restorative. DSS objected to the classification on the basis that restora-

tive therapy must result in actual improvement in the patient's condition, which was not shown with these residents. The nursing home argued that Medicaid had no basis for imposing the standard of actual improvement.

If therapy is not deemed restorative, the RUG designation for that resident will indicate a lower level of care need. This is important to a nursing home because its overall reimbursement rate is determined by its case mix index (CMI). The CMI is based upon a weighted average of the RUG designation given each resident. The higher the CMI, the higher the facility's reimbursement rate.

The Supreme Court found for the nursing home, holding that the actual improvement standard was based upon an unpromulgated rule not properly adopted. The Appellate Division denied the petition, finding that the actual improvement standard was an interpretation of a regulation and not an unpromulgated rule.

In this appeal, the Court of Appeals held that the requirement of actual improvement was interpretive and the interpretation used was not arbitrary and capricious.

DSS, in an action against a refusing community spouse for contribution, appealed from a decision allowing the defendant's answer to include an affirmative defense based on constitutional grounds. *Comm'r, DSS v. Jones*, 1157N, 1157NA (1st Dep't, June 19, 2003).

Defendant, a community spouse with excess resources, was sued by DSS for contribution. Five years after she served her original answer, she moved to amend her answer to include an additional affirmative defense asserting that DSS was discriminating in selecting her case for litigation in violation of her rights of due process and equal protection. The Supreme Court, New York County, granted her motion to amend her answer.

The Appellate Division, First Department, reversed and denied the motion to amend the answer, finding that the defendant failed to provide any evidence of a good faith basis for her affirmative defense.

The administrator of an estate petitioned for the right to exercise her decedent's right of election. Denied. *In re Application of Possick v. Estate of Wurcel*, 23678 (Sur. Ct., New York Co., May 27, 2003).

Esther Wurcel received medical assistance for her nursing home care from 1996 to her death in January 1999. On her death, Medicaid instituted a claim against her estate for $124,000. Mrs. Wurcel's husband died a year before her, leaving her one half of his estate in trust. Mr. Wurcel's nephew was the named executor and trustee under Mr. Wurcel's will and was given a beneficial interest in the estate. The nephew waited until January 2000 to probate the will.

The petitioner, the administrator of Esther Wurcel's estate, argued that the nephew purposely waited a year after Mrs. Wurcel's death to avoid her right of election claim against Mr. Wurcel's estate. She sought to exercise Mrs. Wurcel's right of election to receive one-third of her husband's estate outright subsequent to her death.

The Surrogate's Court, New York County, held that the statute is very clear that a spouse must file an election while alive. If filed prior to death but not collected, the estate can pursue the election amount. If a spouse is incapacitated, there is a possibility of an extension of the filing time. However, the court then explained that if the administrator can show that the nephew committed fraud in delaying the probate for his own interests, a constructive trust could be imposed upon the estate.

Endnote

1. 222 A.D.2d 1082.

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

Legislative News

By Howard S. Krooks and Steven H. Stern

Howard S. Krooks

Governor Signs Bill to Help Seniors in Rent-Regulated Apartments: New Law Will Help Protect Tens of Thousands of Seniors from Rent Increases

Governor George E. Pataki has signed legislation into law that will enable more seniors living on fixed incomes to remain in affordable housing. The new law grants local governments the option to increase the income eligibility limit for the Senior Citizen Rent Increase Exemption (SCRIE) from $20,000 to $24,000.

SCRIE protects eligible seniors who live in rent-controlled or rent-stabilized apartments or certain residential hotel units from most rent increases. SCRIE is available in New York City and eighteen other municipalities in Nassau and Westchester counties (see list at right).

"This new law will help tens of thousands of seniors remain in their apartments by protecting them from unaffordable increases in their rent," Governor Pataki said. "Over the years, the SCRIE program has provided a valuable benefit to seniors living on fixed incomes. By authorizing an increase in the program's income eligibility threshold, we will continue to keep the cost of housing affordable for seniors and help them maintain a high quality of life in neighborhoods where many have lived and worked most of their lives."

Under the SCRIE program, over 44,000 fixed income seniors in New York City alone are saving a total of nearly $70 million each year.

Senator Olga Mendez said, "Senior citizens living on fixed incomes suffer severe problems from the rising costs of living. This new law will enable the state of New York to include even more seniors in the highly successful SCRIE program, protecting tens of thousands of seniors from rent increases. I thank Governor Pataki for signing this bill into law and making sure that our seniors get the protection they deserve. "

Seniors who are 62 or older, live in a rent-controlled or rent-stabilized apartment or residential hotel, and whose disposable household income is under the maximum set by the municipality (not to exceed $24,000) may be eligible for SCRIE if they live in municipalities offering the exemption.

Steven H. Stern

In addition to helping seniors, the SCRIE program also safeguards building owners by fully reimbursing them for the difference between the actual rent and the amount SCRIE-eligible tenants are responsible to pay. Landlords receive dollar-for-dollar tax credits to make up the difference.

In New York City, if a tenant qualifies for this program, the tenant is exempt from future rent guidelines increases, Maximum Base Rent increases, fuel cost adjustments, and increases based on the owner's economic hardship and major capital improvements. Upon moving, senior citizen tenants in New York City may also apply to carry this exemption from one apartment to another.

Outside of New York City, SCRIE is a local option and communities have different income eligibility limits and exemption allowances. The eighteen municipalities outside of NYC currently offering SCRIE are:

Nassau County

- City of Glen Cove
- Village of Great Neck
- Village of Great Neck Plaza
- Town of North Hempstead
- Village of Hempstead
- Village of Thomaston

Westchester County

- Town of Greenburgh
- Village of Irvington
- Village of Larchmont
- Town of Mamaroneck
- Village of Mamaroneck
- City of Mount Vernon
- City of New Rochelle
- Village of Pleasantville
- Village of Tarrytown
- Village of Sleepy Hollow
- City of White Plains
- City of Yonkers

New York State Division of Housing Commissioner Judith A. Calogero said, "This is a powerful program that benefits our seniors who have given so much to this state. It's a great opportunity for government to give something back to them in return for all they have done on behalf of the people of New York."

New York City residents interested in learning more about SCRIE can visit the New York City Department for the Aging online—www.nyc.gov/aging—or contact the 24-hour Information and Referral Helpline—212-442-1000. The Department for the Aging is located on the 6th Floor of 2 Lafayette Street.

Residents outside of New York City should contact the New York State Department of Housing and Community Renewal's Rent InfoLine—(718) 739-6400. Alternatively, residents can contact their County Rent Office. In Westchester County the phone number is (914) 948-4434. In Nassau County, the phone number is (516) 481-9494.

Source—Press Release from Governor George E. Pataki dated August 21, 2003.

Assembly Bill Would Require Banking Institutions to Cash Federal and New York State Checks for Senior Citizens, Even if No Account Maintained at Institution

Assemblyman Christensen has sponsored Assembly Bill A.152, which would require banking institutions to cash checks drawn on federal and state accounts for senior citizens (age 62 or older) with proper identification whether or not such person has an account at such bank (the bill exempts credit unions from this requirement). The bill is presently being reviewed by the Banking Committee.

The justification for the bill pertains to the high cost of maintaining accounts at banking institutions. According to the Sponsor's Memo:

> In today's world, everyone needs access to at least minimal banking services. However, the fees that often accompany banking accounts, requirements regarding minimum balances, and the recent practice of some banks denying persons from establishing accounts with small amounts of money prevent many senior citizens from having any type of banking account.
>
> Without an account, some banks will not cash any checks. This leaves some senior citizens in a precarious, frustrating situation. They either have to find another bank that will cash their check or have someone else cash their check for them.
>
> Passage of this bill will make banking more convenient for senior citizens. In addition banks will not run any risk in cashing these checks because either the state or federal government will honor the check.

We will keep readers posted as to future developments with this bill.

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PRACTICE NEWS

Creating Systems for the Elder Law Office

By Thomas D. Begley, Jr. and Vincent J. Russo

Thomas D. Begley, Jr.

How can we better serve our clients? Our clients are "consumers," and as such they want three things: better, faster and cheaper. "Better" means they want high-quality legal services delivered on a consistent basis. "Faster" means they want a quicker turnaround time; they want their legal services and documents delivered faster than they traditionally have been. "Cheaper" means they want fees that are affordable. To deliver cheaper services, law firms must become more efficient and reduce their costs.

In 1975, Roberta Ramo, then an obscure sole practitioner in Oklahoma, wrote a book for the American Bar Association entitled, *How to Create a System.* The solution to satisfying our clients' needs for better, faster, cheaper, Ms. Ramo wrote, is to adopt systems. (Much of this article is based on the ideas presented in her book, which is unfortunately out of print. Interestingly, Ms. Ramo subsequently became President of the ABA.) Systems can and should be implemented for the operation of each substantive area of law in which the firm engages. Properly designed systems utilizing checklists and forms ensure that high-quality legal services are delivered to the client on a consistent basis, every time. Services can be delivered faster because the system makes the delivery more efficient. Services can be delivered less expensively because the efficiencies brought about by the system reduce the law firm's cost. Profit is the difference between price and cost; by reducing costs the law firm is able to increase profit without raising fees.

The Rationale for Using Systems

There are seven reasons why law firms must use systems:

- To ensure consistent quality
- To produce more work
- To decrease personal tedium
- To release attorneys from routine chores
- To allow more time for work on challenging legal questions
- To simplify staff training
- To simplify the training of new associates

Vincent J. Russo

A separate system should be created for each area of substantive law in which the firm engages. Typical systems in an elder law practice might include Long-Term Care Planning, Estate Planning, Medicaid Applications, Estate Administration, Guardianship, Medicaid Fair Hearings and Special Needs Trusts (or "(d)(4)(A) trusts").

The Essential Ingredients of a Substantive Law System

Gathering Information—The goal here is to gather all of the information needed from the client at the initial client meeting. This requires the law firm to design an intake form to be completed by the client or the firm (or both), as well as a checklist of all items that the client should bring to the initial client conference.

Check Plan—One of the ways to ensure consistency and avoid errors of omission is to include a written check plan in every file. When each file is opened, the check plan should be put on the inside of the file's left hand flap. The check plan has four columns: (1) task, (2) assigned to, (3) completion date, (4) date actually completed. "Task" includes every task to be followed during the course of the representation in that particular area of substantive law. By insisting that all lawyers and staff members complete the check plan, anyone in the firm can pick up the file and know its status at a glance. If every item on the check plan is completed, there will be no error of omission. Consistent quality is assured.

Written Instructions, Directions and Procedures—Lawyers constantly give instructions to associates, staff and clients. Very often these instructions are oral and easily forgotten. Reducing these routine repetitive instructions to written form makes them uniform for every file and easier for the client, the associates, and the staff to follow. Written handouts to clients make it easier for the client to remember what to do and how to do it.

System Binder and Contents—Each substantive area of law should have its separate binder or binders. The format for the binders should always be the same, and should consist of five sections:

- Section 1: check plans and checklists
- Section 2: form letters
- Section 3: document forms
- Section 4: furnished forms
- Section 5: related items

Ninety Percent Rule—The authors believe that there are a finite number of choices to be made in almost any task a firm performs. However, Roberta Ramo uses the 90 percent rule. If something—a clause, a letter, a step on a checklist—is used 90 percent of the time, then it should be included; if not, it should be excluded.

Invest the Time—Setting up a good system requires an investment of time. Do it right the first time, then update it periodically. Nothing exists that can't be made better.

Getting Started—The first step is to select the task to be systematized initially. The most productive choice would be the largest area of the firm's practice. By systematizing this area first, the big payoff will be achieved immediately. This will also be the most difficult area to systematize, because it will most likely have the largest number of steps, forms, documents, etc. Alternatively, some commentators have suggested systematizing a smaller area of practice first to get the feel for developing the system.

The next step is to gather five existing files as samples and review the legal requirements for each. Prepare a check plan listing each step the law firm takes throughout a typical representation in that substantive area of law. Draft each of the documents. These can be taken from the best existing documents the law firm has in its files or from form books that are readily available. Draft the letters. Again, these can be taken from the best letters available in the firm's file or from form books. Number all of the forms, letters, furnished forms, etc., on the check plan and on the documents and letters themselves. Gather the furnished forms. Complete the variable information. Collect the related items. Complete the system and update it periodically.

Sixteen-Step Method. The above process for creating a system can be divided into sixteen discrete steps:

- Choose the Subject Area for the System
- Select the Team That Will Design and Implement the System
- Prepare the Check Plan
- Gather the Documents
- Analyze Communications Within the Office
- Review the Law
- Accumulate the Furnished Forms
- Draft Letters for the System
- Analyze Communications That Produce No Written Documents
- Analyze Materials That Come from Outside the Office
- Draft Practical Hints
- Review and Redraft the Documents
- Prepare a Significant Date List
- Draft the Master Information List
- Tie the Master Information List to the Forms
- Put It All Together

Law Firm Operations System

The law firm should also have a system in place for handling a file from the initial telephone call to the time the file is closed. While the substantive law systems are designed primarily to ensure consistent high quality in the work product, the operating system is designed to ensure high quality in the delivery of the work product. This system is designed to ensure efficiency and excellent client service from beginning to end. The following is an outline of one suggested approach:

Initial Telephone Call—The initial telephone call should be handled by the receptionist, who immediately directs it to a scheduling secretary. Lawyers should never make their own appointments.

File Preparation—The scheduling secretary then prepares a file. Files are color-coded by area of practice and are divided into "single" or "married" where that division is appropriate. The scheduling secretary prints out a check plan and affixes it to the inside left-hand flap of the file. The secretary prints out the initial client letter with directions to the appropriate law firm office, an intake form, a firm brochure, a firm newsletter, and an audiocassette describing the firm's services in the area of practice that the client needs, if the firm does this. The initial client letter is mailed

within 24 hours of the appointment being scheduled. The file is assigned a number and placed in the current file drawer. The number is added to the firm list of file numbers, which is integrated with the firm's time and billing system. The scheduling secretary prints out an Answer Sheet to be used by the attorney at the initial client conference that ties into the document assembly system. If there are any special notes, these are entered into the database and printed out and placed in the file.

Confirmation of Appointment—Twenty four hours prior to the scheduled appointment, a secretary calls to confirm the appointment with the client and to remind the client of the importance of completing the intake form and bringing in all the items requested in the initial client letter. Directions to the office are confirmed. The secretary must pull the client file in order to confirm the appointment and then places it in a special drawer for clients scheduled for appointments on the following day.

Initial Client Conference (PreConference)— Upon the client's arrival, the Personal Assistant ushers the client into a conference room, reviews the client's intake form for completeness, and gathers all the data the client was asked to bring. The Personal Assistant then takes the client's picture on a digital camera to be placed in the client file and sets up the tape recorder so that the client conference can be recorded. The Personal Assistant then leaves the conference room to get the responsible attorney. The Personal Assistant tells the responsible attorney the client's name and then makes sure that required copies of information brought by the client are made by the copy person.

Initial Client Conference (Attorney)—The attorney enters the conference room, greets the client by name, and asks him to outline his goals for the meeting. This is an important step. It forces clients to begin the process of understanding what he is trying to accomplish. Clients are often sent by family or friends and have only a general idea of what they are trying to accomplish. Part of the marketing approach with an individual client is to have the client understand the position he is in and his need for legal representation, and for the lawyer to begin to manage the clients' expectations about the outcome.

Once the client has stated his goals, the lawyer should carefully review the facts, the goals, and the legal strategies available to achieve those goals based on the facts presented. Clients should never be rushed. During the client consultation, the various strategies should be discussed in depth and the lawyer should use a written checklist. The client should see the lawyer using this checklist and should leave the appointment with the impression that the lawyer was very thorough.

If documents are to be prepared as part of the representation, the client's choices should be discussed. This discussion should be in-depth and the Answer Sheet should be completed, as this will form the basis of preparing the documents through the law firm document assembly system. There should be little or no drafting by the lawyer after the client conference ends. Let the client see the work being done.

At the end of the conference, summarize the client's present position and what will happen without good legal representation. Then summarize for the client where he will be if, through good legal representation, his goals are achieved. Quantify the difference. Then explain the fee. If the client understands where he will be with and without legal services, the value of the services and the reasonableness of the fee will be apparent. Unless they are being billed hourly, clients don't care how much time a lawyer will spend on a matter. They care about the value of the legal services. Clients understand that there is a difference between a Monet and hotel room art. The attorney reviews the Engagement Letter with the client and obtains the retainer. It is suggested that one-half of the total fee be collected as the initial retainer, with the balance due upon execution of the documents. The Personal Assistant takes the retainer check and forwards it to the law firm's comptroller for processing.

Engagement Letter—At the end of the client conference the lawyer asks if the client wants to retain the firm. At the Begley firm, the answer is "yes" ninety-four percent of the time. The lawyer should then have the Personal Assistant prepare the Engagement Letter. Also at the end of the client conference, the attorney or legal assistant gives the client a card confirming the follow-up appointment. The card should have the Personal Assistant's direct phone number, and the attorney should explain that the Personal Assistant is more available than the attorney and is often able to provide answers on the spot. If the Personal Assistant is unable to provide such answers, the Personal Assistant will have the attorney call back as soon as possible, always within the same business day. Always get the client's home telephone number so that the call can be returned after hours, if necessary.

Post-Initial Conference (Secretary)—Whenever possible, the follow-up conference should be scheduled at the initial conference to cut down on unnecessary phone tag.

Attorney Action Post-Meeting—(Drafting Documents and Letters)—Within 24 hours of the initial client conference the attorney must take whatever action can be taken with respect to the file. In transactional work this often means drafting documents or letters to third parties, or both. These actions must be completed by the attorney within 24 hours and the file delivered to the secretary for document preparation. When the attorney drafts the documents, she also completes the check plan on the inside left flap of the file outlining all the steps that need to be taken. She assigns the tasks and establishes the deadlines. She then enters the same information on the law firm's case management system. The tasks are assigned to specific persons and deadlines are given electronically as well as in writing. The system should be designed so that the electronic deadlines appear both on the responsible attorney's computer screen as well as that of the responsible staff member. Every Friday every staff member should report to the office manager or the responsible attorney regarding "To Dos" that are incomplete and the reasons why.

It is essential that, regardless of the practice area, a planning letter summarizing the initial client meeting be included in the document package that the lawyer delivers to the client. This letter should contain the following sections:

- Background—This is a brief outline of the facts as related by the client to the lawyer.
- Goals—This is a brief restatement of the client's goals.
- Applicable Law—How will the law affect the client's situation? This is generic.
- Strategy—Based on the facts of the situation, what is the strategy to achieve the client's goals? This is the meat of the letter.
- Variables—What are the unknowns that will affect the outcome?
- Action Plan—What actions will be taken by the lawyer, by third parties, and by the client? How will these affect the outcome?

Attorney Review—The secretary doing the document preparation should be given 48 hours to complete the task. The file is then returned to the attorney to review the completed documents. The attorney should receive them no later than 11:00 a.m. By 2:00 p.m. the attorney should have reviewed the completed documents and returned them to the document preparation department for transmittal to the client, third parties, or both. It is important to set deadlines, although make sure that they are reasonable.

Confirmation—(Second Client Meeting)—Forty-eight hours prior to the second client meeting the confirming secretary should contact the client and remind him of the appointment.

Prepare Binder—Prior to the client returning to the office for the signing ceremony, a binder should be assembled. While the binder cannot be completed until all documents are executed, portions of the binder can be assembled, thereby reducing waiting time at the signing appointment. The goal should be to deliver the binder to the client at the conclusion of the execution ceremony.

Second Client Appointment—At the second client appointment, any documents that need to be signed are reviewed and executed. The action plan, as proposed, is agreed upon between the client and the firm. The balance of the legal fee is paid and client questions are answered. At this point, the client should have complete confidence in the law firm and be comfortable with the representation being provided.

Documents to Client—If documents are to be signed at the second meeting, they should be placed in a binder and delivered to the client at the meeting's conclusion.

Off-Site Document Execution—Often, clients are unable to travel to the lawyer's office, requiring the lawyer to visit the client to obtain all of the necessary signatures. A written procedure for this practice should be in place.

Post-Second Meeting Action—If action is required subsequent to the second meeting and such action can be taken by either the law firm or the client, it should be taken by the law firm. Clients are often unsophisticated and don't have the time or skill required to complete seemingly routine tasks. Within 48 hours of the second meeting, any action required to be taken by the law firm should be initiated. Letters to third parties should be sent, follow-up appointments scheduled, arrangements with third parties made, etc. To the extent possible, law firms should charge flat fees. Clients should be encouraged to call the law firm with any follow-up questions and to return for another consultation, if desired. The cost of this follow-up should be built into the initial fee. If the law firm is going to be perceived as offering excellent client service, it is the follow-up services that make the difference.

Closing the File—When all of the action required by the law firm, the client, and third parties has been completed, the file should be closed. This

can be done in a number of ways. The file can be placed in storage in the basement or in an off-site storage facility. The ideal way to close a file is to close it electronically.

When the file is closed, a disengagement letter is sent to the client. The disengagement letter notifies the client that the matter is concluded and the firm is no longer responsible to perform additional work. This is also an opportunity for the firm to market other services to the client. The disengagement letter should be pleasant but clearly a disengagement.

Technology

The use of technology is essential to a law office system. Whatever is being done manually, the attorney needs to consider how to translate that action item into a computerized law office system. Database programs (such as Time Matters or Amicus) hold the answer. A quality database program will allow firms to manage every aspect of a case and allow easy access to all relevant information and documentation on a particular client or matter without the need to access the hard copy of the file.

All of the steps outlined in this article can be programmed into the database program so that the staff person can be prompted about what needs to be done rather than relying on his memory or a manual system, which requires affirmative action on the staff person's part. Also, since by nature elder law practices are based on high-volume and single transactions, it is impossible to properly manage one's caseload by memory or even a manual system. The ability to review the status of an entire caseload is possible only through the database program.

An even more powerful benefit of a database system is the ability to obtain a report on a particular type of matter or all cases at a specific stage in the work process. For example, a database system can quickly generate all the cases that require the filing of a Medicaid application in a given month in order to preserve the pick-up date, or the number of cases where the attorney is still awaiting the return of a deed from the county clerk's office. A database program requires a serious time commitment by attorneys and staff to create it and teach personnel how to use it. On the other hand, without a database program, there is no way the attorney will be able to compete with his or her colleagues who utilize technology to the fullest in meeting consumer demands.

Conclusion: A Plan for Success

The pressure is on the legal profession to meet consumer demands for better, faster and cheaper service. The key to meeting these demands is to establish a law office system, use it and constantly strive to improve it. This article has offered step-by-step guidance on how to create such a system. Every law firm will have different approaches to the various steps that make up the system; there is no one right way. The most important step, however, is to start somewhere, even if you only address one small aspect of the overall system. You can always then add to the system, one step at a time. But in order to be successful, you must have a law office system. There is no other way.

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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 H. Reixach, Esq., at Woods Oviatt Gilman LLP, 700 Crossroads Building, 2 State Street, Rochester, New York 14614. We will publish synopses of as many relevant Fair Hearing decisions as we receive and as is practicable.

In re Appeal of D. K.

Holding

Ellice Fatoullah

Where a married Medicaid applicant is taking periodic payments from his IRA in an amount which would deplete the principal over his life based on the IRS required minimum distribution table, the Agency may not require the applicant to increase the periodic payments to an amount based on the single-sex life expectancy table in Administrative Directive 96 ADM-8.

Facts

A Medicaid application was filed on September 23, 2002 for chronic care coverage for the Appellant, who had resided in a residential health care facility since December 2001, after a period of hospitalization. The Appellant is married and was age 78 at the date of the application; the Appellant's wife was age 73 at the date of the application, and she continues to reside in the community.

The Appellant had an IRA which had a net asset value of $202,076.78 on September 25, 2002. At the hearing the representatives of the parties stipulated that the amount to be considered should be the net asset value as of September 1, 2002, that being the date of assessment of the Appellant's financial circumstances; and they agreed that documentation of that amount would be obtained, and when available, would replace the September 25, 2002 statement.

The Appellant elected to commence regular monthly withdrawals from his IRA in 1995. Currently the withdrawals are at the rate of $915 per month, equivalent to $10,980 per year, based on the "minimum pay out" rate permissible under an actuarial table used by the Internal Revenue Service. The IRA provides that monthly withdrawals shall continue for the life of the Appellant, then continue for his wife, his designated beneficiary.

René H. Reixach

On November 26, 2002, the Agency made a written request to the Appellant's counsel to have the Appellant's IRA withdrawals increased to an amount shown in the actuarial life expectancy table for males in New York State Department of Social Services Administrative Directive 96 ADM-8, requiring full withdrawal within 7.83 years. At that rate, the monthly withdrawal would have been $2,150.67, or $25,808.04 per year. The Agency repeated that request in writing on January 6, 2003.

Neither the Appellant nor anyone acting on his behalf has taken any action to comply with the Agency's request, disputing the request and contending that the Appellant has the right to maintain his previous rate of withdrawal, scheduled to continue over a 19.2-year life expectancy.

By notice dated January 30, 2003, the Agency determined to deny the Appellant's application for Medicaid. The reason given was the Appellant's failure to "maximize [Appellant's] American Express IRA per the life expectancy tables, as requested 11/26/02 and 1/6/03."

On March 7, 2003, a request for a Fair Hearing was made on behalf of the Appellant.

Applicable Law

Section 360-4.1 of the N.Y. Comp. Codes R. & Regs. title 18 (the "Regulations") provides that all income and resources available to an applicant/recipient during the period for which eligibility is

being determined will be evaluated. Certain amounts and types of income and resources will be disregarded; the remainder is the applicant's/recipient's net available income and resources.

Section 360-4.10 of the Regulations provides for the Treatment of Income and Resources when a married Medicaid applicant or recipient requires institutional health care and his or her spouse continues to reside in the community.

An Administrative Directive (96 ADM-8) issued by the New York State Department of Social Services advised local districts of changes in the treatments of transfers and trusts in the Medicaid program as a result of the federal Omnibus Budget Reconciliation Act of 1993. Attached to that Directive are two Life Expectancy/Actuarial Tables (Attachment IV), one for females, the other for males.

A general Information System Message addressed to local social services districts on August 11, 1998 (GIS 98 MA024) clarified statewide policy concerning the treatment of retirement funds for the purpose of determining Medicaid eligibility. That clarification reflected the eligibility requirements of the Supplemental Security Income (SSI) program, but the clarification applies to all Medicaid applicants and recipients. That Message described retirement funds as annuities or work-related plans for providing income when employment ends (e.g. pensions, disability, or other retirement plans administered by an employer or union; individual retirement accounts; and plans for self-employed individuals).

More specifically, that Message further provided that Medicaid applicants/recipients who are eligible for periodic retirement benefits must apply for such benefits as a condition of eligibility. If there are a variety of payment options, the individual must choose the maximum income payment that could be made available over the individual's lifetime. (By federal law, if the Medicaid applicant/recipient has a spouse, the maximum income payment option for a married individual will usually be less than the maximum income payment option that is available to a single individual.) Once an individual is receiving periodic payments, the payments are counted as unearned income on a monthly basis regardless of the actual frequency of the payment. That Message also provides that once an individual is in receipt of, or has applied for, periodic payment, the principal in the retirement fund is not a countable resource, even if the individual has elected [to withdraw] less than the maximum periodic payment amount and this election is irrevocable.

Discussion

At the outset, inquiry was made regarding the absence from the hearing of both the Appellant and his wife. Both counsel expressed their belief that, despite the general preference to have all the parties personally in attendance, neither the Appellant nor his wife is actually necessary in this instance because, with the exception of a relatively small discrepancy between the net asset value of the Appellant's retirement account as of September 25, 2002 and the correct net asset value as of September 1, 2002, there is no issue of fact. The hearing solely seeks resolution of disputes regarding matters of law.

The Agency's attorney stated that there is no issue related to any available resource, but that the only issue concerns the Agency's treatment of income, the action under review being a denial of Medicaid for failure to maximize the amount of monthly payments from the Appellant's retirement account. He called attention to the Appellant's existing plan of monthly withdrawal based on a pay-out rate permitted by the Internal Revenue Service that the Agency believes to be substantially lower/slower than the "maximum income payment option" required under current state law and policy.

More specifically, he showed that the Agency has asked the Appellant's attorney (more than once) to have the periodic withdrawal amount increased to a rate consistent with the Life Expectancy Table found at Attachment IV of 96 ADM-8, noting that the life expectancy of a 78-year-old male is 7.83 years. Assuming the retirement account balance to be what had been shown in the September 25th statement, the required increase would be from $915 to $2,150.67 per month.

The Appellant's counsel, on the other hand, contended that the increase the Agency seeks is merely suggested by the content of a GIS message, is not mandated by any provisions of statute or regulation, and therefore is not required by unambiguous provisions having the force of law. She also argued that the longevity table attached to 96 ADM-8 was not intended to be used in the way the Agency proposes, and is included at Appendix IV solely to guide actuarial projections in evaluating a transfer of a "stream of income" as discussed at subsection H(2) (top of page 18) of the Directive.

The Appellant's counsel further contended that, because the Appellant previously chose to with-

draw funds at the minimum rate permitted by the IRS (withdrawals are taxable as ordinary income, under provisions of the Internal Revenue Code), the Appellant has no legal obligation to increase the payments or the rate of withdrawal. Moreover, doing so could more rapidly exhaust the balance of the retirement account, to the detriment of the Appellant's wife, who has a longer life expectancy. In advancing the Appellant's position, his counsel made no claim that the Appellant's election to take the minimum permissible rate of withdrawal was irrevocable, or that he had no authority to change the amount or rate in the manner requested by the Agency.

Review of current state law and policy fails to reveal adequate legal authority for the action under review. Although failure to apply for income or benefits that an applicant has the right to receive may result in denial of a Medicaid application for failure to meet one of the conditions of eligibility, the Appellant in this case already was receiving the benefits, merely in amounts that are less than what the Agency considers the "maximum income payment option." Under the circumstances, the determination under review cannot be affirmed.

However, to avoid further delay in completing a proper evaluation of an application made several months ago, it must also be admitted that the point made by Appellant's counsel is well taken; there is simply no current legal authority supporting the policy objective of requiring a "maximum income payment option" in cases involving a community spouse. While there is legal authority for an individual seeking Medicaid to generally be so required, there exists no legally-sanctioned longevity table for use in any case involving a couple.

Fair Hearing Decision

The determination to deny the application for Medicaid submitted on behalf of the appellant, solely based on failure to change the amount of the retirement account withdrawals to the "maximum income payment option," is not correct and is reversed. The agency is directed to take no further action on its denial notice, and promptly to complete its calculation of the Appellant's net available monthly Income, including all income actually received.

Editor's Comment

This decision answers one question about the treatment of retirement accounts which are in periodic payment status, but it leaves others unresolved. While it holds that there is no requirement that the single-sex life expectancy tables in Administrative Directive 96 ADM-8 be used in cases where the applicant/recipient is married, what if the applicant/recipient were not married? While there is dicta in the last sentence of the Discussion that might be read to imply that use of the tables in 96 ADM-8 could be required if the applicant is not married, that statement also could be read merely to imply that as a general rule individuals are required to apply for the maximum amount of income available to them from any source.

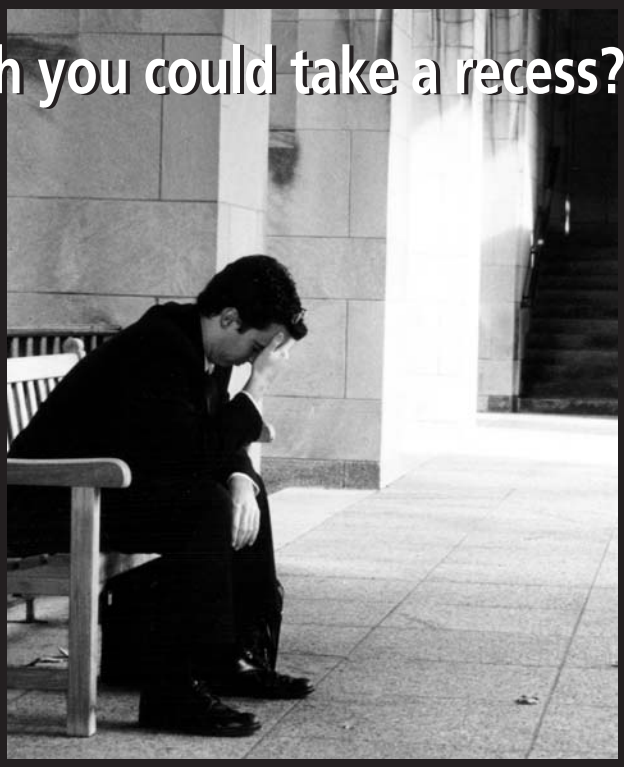
The Discussion also touches on, but does not squarely address, an issue applicable to periodic payments from retirement accounts for both married and unmarried individuals. There is no regulation that says that periodic payments from an exempt retirement account must be taken in an amount computed pursuant to the life expectancy tables in 96 ADM-8. For the state to impose such a requirement without such a regulation would violate the State Administrative Procedure Act. Likewise, there is not even any such requirement in the GIS and Medicaid Reference Guide section concerning retirement plans or in 96 ADM-8. This undoubtedly will be the next issue to be resolved about periodic payments from retirement accounts in a Fair Hearing for an unmarried individual.

While the decision after Fair Hearing was favorable to the Appellant, had he been unsuccessful, there could have been substantial adverse consequences since a new application (based on requesting an increase in the monthly pay-out) only could have been filed after the decision was issued in July 2003, so any coverage for the prior ten months could have been lost. That risk could have been minimized if the Appellant had promptly increased the monthly withdrawals as initially requested November 26, 2002, but had done so under protest reserving his right to challenge that requirement through a fair hearing. While that would have caused the Appellant unnecessarily to withdraw an additional $1,235 per month for seven to eight months, all of which would have been applied to his cost of care, that risk had a substantially lower possible cost to him than the cost of ten months of care that was at risk from the course of action actually taken.

The Appellant at this Fair Hearing was represented by Lisa M. Powers, Esq., Philips, Lytle, Hitchcock, Blaine & Huber LLP, of Rochester, New York.

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

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



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Advance Directive News

No Clear Directions: The Doctor's Dilemma

By Ellen G. Makofsky

Every day hospitals are faced with the predicament of the critically ill patient who suffers from dementia and has no advance directive in place. Advances in modern medicine have swelled the population of those in demented states suffering from a variety of serious ailments and lacking the capacity to direct their own health care. New York State requires that physicians have "clear and convincing evidence"[1] of a patient's wishes before withholding treatment. Without an advance directive, or cogent direction from the patient, physicians are compelled to do all they can.

According to *The New York Times*, a recent government study established that only 35 percent of people with severe cognitive impairment have an advance directive. Cognitively impaired New Yorkers fall below the national average because only 26 percent of them have advance directives.[2] This creates the doctor's dilemma.

Dr. Lewis R. Goldfrank, the director of Bellevue Hospital's emergency room in New York City, articulated his dismay. He said, "They send these patients to us to treat and we do them a disservice. We do things for them I wouldn't do for my own mother. The problem is, we don't know how to die in America."[3] Dr. Gregory Mints, who practices at Bellevue Hospital, was graphic in his discussion of a patient in a persistent vegetative state who lacked an advance directive and was repeatedly sent to Bellevue for treatment of chronic infections. "He can't communicate . . . For all practical purposes, he is dead. Rats you know, die of kidney failure. Humans die of heart attacks. That's the common way we die. We have the technology to fix the heart, so as a result we rot. We just rot away. These people come here and, in many cases, we have to torture some of them."[4]

I was recently appointed Court Evaluator in a guardianship proceeding where the AIP underwent bypass surgery and among the other complications that occurred, the man became ventilator dependent. Prior to the surgery the AIP lived in an adult home. He had a history of schizophrenia. He lacked the cognitive ability to direct his own care. The AIP had many physical woes and a question regarding the insertion of a feeding peg came up. The hospital initiated the guardianship proceeding because there was no family member involved in his care and no advance directive to provide insight as to the AIP's wishes.[5] The hospital petitioned to have a guardian appointed so that, among other things, someone would be empowered to direct the AIP's health care. Eventually a guardian was appointed. Research was done to determine if the AIP had ever executed an advance directive or whether anyone could present clear and convincing evidence of the man's wishes. Nothing could be found. This left the appointed guardian with no ability to later order the feeding peg removed. The AIP was eventually transferred to a nursing home on a ventilator and with a feeding peg. He will continue to receive his doctor's best efforts to keep him alive. Some of the treatment will be painful, some treatment will strain what dignity the man has left, and most of the treatment will be futile as he drifts in and out of a nether world.

What to do? We already counsel our clients about the importance of executing advance directives such as living wills and health care proxies. Many of us speak at forums to educate the public on these issues. Hundreds of us participate in the New York State Bar's Decision Making Day and yet so many New Yorkers still lack the basic documents to effectuate a health care plan. As elder law attorneys we must do more. We must advocate for change. New York currently requires the stringent "clear and convincing evidence" standard for health care decision making while other states use a substitute decision-making standard. Modern medicine has changed and is capable of providing a kaleidoscope of medical interventions never imagined years ago. Legislation also needs to change so that New York can move from yesterday to today. Think of the clients you have and the health care decision-making issues you address in your office and write your legislator.

Endnotes

1. *In re Eichner (In re Storar)*, 52 N.Y.2d 363, 438 N.Y.S.2d 266 (1981); *In re Westchester County Medical Center On Behalf of O'Connor*, 72 N.Y.2d 517, 534 N.Y.S. 2d 886 (1988).
2. Kleinfield, *Patients Whose Final Wishes Go Unsaid Put Doctors in a Bind*, N.Y. Times, July 19, 2003, at B2, col. 1.
3. Kleinfield, *supra,* at B1, col. 5.
4. Kleinfield, *supra,* at B2, col. 4-5.
5. The feeding tube was subsequently inserted prior to the appointment of a guardian.

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2004

New York State Bar Association

Annual Meeting

January 26-31, 2004

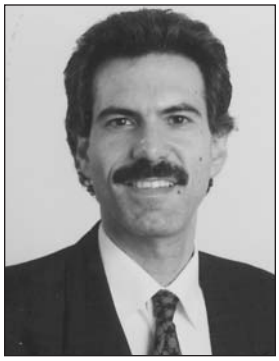
New York Marriott Marquis
New York City

Elder Law Section Meeting
Tuesday, January 27, 2004

Public Policy News

Elder Law Section: Legislative Advocacy

By Ronald A. Fatoullah



The following article presents the position of the Elder Law Section of the New York State Bar Association regarding two important pieces of legislation as decided by the Section's Executive Committee on August 14, 2003.

First, the Section supports New York State Assembly bill A.84, sponsored by Assemblywoman Susan V. John and co-chaired by several Assemblypersons, including my Vice-Chair of the Public Agency and Legislation Committee, Ann Corrozza. Similarly, the Section supports the New York State Senate's companion bill S.232, sponsored by Senator Malcolm A. Smith.

Both versions seek to increase the monthly personal needs allowance (PNA) for residents of certain residential health care facilities receiving or eligible to receive supplemental security income payments and/or additional state payments from $50 to $100 per month. The last such increase in the personal needs allowance was made in 1981. Since then, inflation has severely eroded the true value of the PNA. Even the proposed increase of the PNA to $100 per month would likely not have the same purchasing power of $50 in 1981.

The sponsors' memo states:

> [t]he people who receive this allowance are mainly senior citizens who reside in skilled nursing facilities, some of whom depend solely on social security and SSI or other forms of assistance. All of them are on fixed incomes that depend on this allowance to pay for everything from their clothing, toiletries and laundry supplies to the few luxuries they can allow themselves, such as cable television, which costs half of their monthly allotment . . . So, while nursing home residents have received increased funds for the services they provide, the residents have received no adjustment in the money available to them. Surely in this time of relative prosperity, we can see that the residents of these facilities have access to adequate funds to allow them to receive the same cost of living adjustment that we deem so valuable for ourselves.

Second, the Elder Law Section has opposed, on technical grounds, bills introduced by New York State Senator Meier which seek to change federal Medicaid eligibility and spousal rules as follows:

a. eliminate spousal refusals in both an institutional and community based setting;

b. extend the look-back period on *all* transfers from 36 to 60 months; and

c. create a Medicaid penalty period for home care.

Senator Meier's proposed legislation asks that New York State seek federal waivers in order to implement these changes. The sponsors' memo to the bill states: "We can't continue to place the burden of long-term care expenses on the backs of State tax payers when these families often have significant resources to cover the expenses or insure against the risk . . . Nobody expects taxpayers to build them a new house if they suffer loss in a fire. Instead they protect themselves with insurance. . . ."

The sponsors' memo asserts that individuals will not insure themselves appropriately (with long-term care insurance) but rather they will rely on Medicaid for future long-term care needs. This position may sound compelling to the lay person, but certainly oversimplifies the realities that elder law practitioners face in their daily practice.

Take, for instance, an experience I had a few years ago at a community lecture I gave outlining long-term care and the Medicaid rules. Throughout the lecture there was a gentleman who made his position known with constant objections, stating, "Why should my hard-earned tax dollars go toward someone else's nursing home bills?" and, "Old people should save up and pay for their own care . . . it's not my problem!" Six months after I gave this lecture, I entered my conference room to greet a new client seeking to obtain care for his mother. I immediately recognized the client as the same gen-

tleman that had argued against Medicaid planning from the lecture.

Unfortunately, his mother now needed medical care for an extended period of time and her assets were dissipating quickly and he wanted to make sure that at least some of her funds would be protected to ensure to provide for her needs beyond.

Elder law attorneys, and certainly my firm, routinely advise clients to purchase long-term care insurance if the client possesses sufficient assets and/or income to afford it, and if the client can pass the medical requirements imposed by the insurance companies. Further, by no means would we advise wealthy clients to divest themselves of assets for Medicaid planning purposes. Instead, we would seek to devise an estate plan for our wealthy clients in order to reduce or eliminate estate taxes. In fact, a new survey conducted by the National Academy of Elder Law Attorneys dispels the myth that elder law attorneys routinely work with millionaires and get them on Medicaid. The survey showed that 79% of Medicaid planning cases had estates of $300,000 or less!

It must be clearly noted that the Elder Law Section opposed the Meier proposals on *technical grounds*; it did not debate the substantive issues of this legislation.

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Guardianship News

By Robert Kruger

A Call to Action

At this writing, the State of the Union in the world of guardianship is troubled, with its genesis resting on the ill-considered letter of two politically connected Brooklyn attorneys, which revealed the interlocking web of political alliances between attorneys and judges in Brooklyn first and eventually, statewide.

One result of this scandal, as we know all too well, is Part 36 of the Rules on Fiduciary Appointments. By placing limits on the amounts attorney can, in any given year, earn, limits here been placed on judicial discretion. In the opinion of this author, the new rules manifest a profound distrust of judges. By removing discretion from judges, we attorneys are swept up in the wash.

Another result has been orchestrated judicial turnover. The prior practice of having one judge preside over a specialized part (the norm in the Second Department) or having four judges presiding over guardianship (as was the practice in New York County) has been discarded. Now, in addition to new fiduciary rules, we have new judges, many of whom are neither interested nor sympathetic to the problems guardianships present, particularly in the contested cases.

Perhaps the biggest challenge for the Bar, in the face of these changes, is lack of consistency and uniformity. There is very little predictability from county to county, and from judge to judge sitting in the same county, regarding (a) the necessity of medical testimony, (b) the refusal of some judges to sign orders to show cause in infants cases, (c) the failure to hold hearings, timely or not at all, (d) the appointment of court evaluators who are clueless and care not one bit, (e) the appointment of independent guardians when qualified family members are ready to serve, (f) the refusal (in some instances) to consider Medicaid planning applications, and (g) the untimeliness of signing orders and holding hearings, and more. Taken together, the process amounts to nullification of Article 81.

What Should Our Reaction Be?

The author believes that judicious appeals are in order, when a clearly erroneous decision has been made. It is important to avoid casual recourse to the appellate courts, because we need to build on good cases to win those that are less than clear. For example, a marginally inadequate counsel fee award might not make a judicious appeal; a truly inadequate award, on the other hand, might be well worth appealing. The Guardianships and Fiduciaries Committee is not the Supreme Soviet: no one is in the position to control which appeals are taken, but we can urge attorneys contemplating appeals to seek out the advice of other practitioners as a sounding board.

Other appellate issues that have strong decisional foundation now include the appointment of an independent guardian where a qualified family member has been bypassed.[1] Yet another issue that cries for appellate treatment is the refusal of some courts to consider, much less decide, requests for Medicaid planning. After *In re Shah*, what could be clearer than the legitimacy of Medicaid planning in the appropriate case?

The Chair and Vice Chairs of the Guardianships and Fiduciaries Committee have decided to suggest that a brief bank, i.e., a repository of appellate briefs, be collected, so that practitioners contemplating appeals will not have to reinvent the wheel on issues previously (and successfully) brought up to the respective Appellate Divisions.

More than simply collecting briefs is contemplated; the Chairs of county elder law committees of county bar associations, if interested, could become the contact points for collecting briefs, acting as informal advisors, and perhaps more importantly, acting as contact with local bar associations' leadership on Article 81 nullification issues.

Going further, we propose to mount a training program for law secretaries to guardianship judges. The training might accomplish more than appeals might accomplish on the timeliness issues, and might, in contested cases, lead to more insightful and sensitive treatment of these matters.

Anyone who lived through the past three years of Bar Association futility where the Birnbaum Commission was deciding our fate while we, who know

the issues and problems of guardianship, were denied any meaningful role in the creation of these rules . . . were it not for the protean efforts of attorneys such as Ira Salzman, Vice Chair of this Committee, and Joan Robert, Chair of the Section, the rules would have eviscerated the elder law bar.

The Guardianships and Fiduciaries Committee must (and will) appoint subcommittee Chairs, with statewide reach, to attempt to activate this nascent structure and make it a force for the values which we feel must be respected if Article 81 is not to be neutered.

* * *

Lest this be thought the only issue on the agenda of the Committee, there are at least two that should command our attention:

1) **Transition between guardianship and estates upon death of the IP:** This is an unsettled area of the law, touching on the continuation of unfinished business of the guardianship (i.e., recovery of assets misappropriated from the IP) as well as payment of final administrative expenses of the guardianship, and more. A well-known trusts and estates attorney in Manhattan, Jonathan Rikoon, has written a paper for the Trust and Estates Section of the State Bar which presents a carefully researched number of legislative suggestions which, the author suggests, will provide a basis for considering these issues. At the summer meeting in Newport, a subcommittee to consider these issues and report thereon will be appointed. Anyone interested in this issue who was not in attendance at Newport should contact the author, who will put that attorney in touch with the subcommittee Chair to work on the subcommittee.

2) **Simplified Final Accountings:** We are well aware that Surrogate's Court has simplified procedures, such as waivers and consents, to speed the estate to conclusion without waiting years. Nassau County has such a procedure now. Seemingly requiring little more than an amendment to MHL § 81.34, Vice Chair Ira Salzman will chair this subcommittee with hopes of drafting a legislative proposal by spring. As with all other subcommittees, volunteers are eagerly sought to work with Ira on this issue.

* * *

This article cannot end without mentioning the two other Vice Chairs of the Guardianships and Fiduciaries Committee, Anthony Enea of Westchester and John Dietz of Nassau/Queens, both of whom will be active on the subcommittees contemplated in this article. Both have expressed interest in training for law secretaries and both will, no doubt, head at least one subcommittee for us. Both are sophisticated attorneys in guardianship, and passionate about the subject, and the author urges members of the Committee to reach out to them and join the Committee's efforts this year. There is much to do and we need your help.

Once again, 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.***

Endnotes

1. One such appeal in Westchester County was never filed, although the brief was written, because of the death of the IP.

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

Capacity News

Capacity Required to Execute a Health Care Proxy by One Who Is Suffering from a Mental Illness or Defect

By Michael L. Pfeifer

In this issue we will address the question of what capacity is required to execute a health care proxy by one who is suffering from a mental illness or defect.

The definition of capacity in the context of executing a health care proxy is contained in Public Health Law § 2980:

> "Capacity to make health care decisions" means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision.

Public Health Law § 2981(1)(b) sets forth the evidentiary standard for determining capacity:

> For the purposes of this section, every adult shall be presumed competent to appoint a health care agent unless such person has been adjudged incompetent or otherwise adjudged not competent to appoint a health care agent, or unless a committee or guardian of the person has been appointed for the adult pursuant to article seventy-eight of the mental hygiene law or article seventeen-A of the surrogate's court procedure act.

Given the presumption of competence, it would seem that a litigant challenging the capacity of a principal to execute a health care proxy would bear the burden of proof. However, in *In re Martin*, the court shifted the burden of proof by clear and convincing evidence to the proponent of the health care proxy where there was medical evidence of mental illness or defect. Specifically, the court held:

> In light of the presumption of competency, the burden of proving mental incompetence is upon the party asserting it (see *Smith v. Comas*, 173 A.D.2d 535 ; *Feiden v. Feiden*, 151 A.D.2d 889; *Matter of Obermeier*, 150 A.D.2d 863, 864). However, where there is medical evidence of mental illness or a mental defect, the burden shifts to the opposing party to prove by clear and convincing evidence that the person executing the document in question possessed the requisite mental capacity (see *Hubbard v. Gatz*, 130 A.D.2d 622, 623; see also *Matter of Shapiro*, NYLJ, Apr. 19, 2001, at 25, col 1).[1]

Is this holding correct? The author respectfully submits that this holding is not justified by the cases cited by the *Martin* court and in fact, the said holding may be in derogation of the Constitution of the State of New York and the statutory scheme of PHL § 2980, et seq.

It is true that in accordance with PHL § 2981(1)(b), if the person executing the health care proxy has been adjudicated incompetent or a guardian appointed for him, then there is no presumption of competence. However, the statute does not call for a shifting of the burden of proof to the proponent of the health care proxy. Furthermore, there are many cases that hold that the mere fact that an individual is suffering from a mental condition does not render him incompetent.[2] And as will be seen below, the *Martin* court's shifting of the burden of proof may be unconstitutional.

The author reviewed all of the reported cases cited by the *Martin* court.[3] None of the cases cited by the said court addressed the issue of capacity to make health care decisions or to execute health care proxies. *Smith v. Comas* involved the sale of real estate by an alleged mentally ill person and the court held that the "burden of proving mental incompetence is on the party asserting it."[4] *Feiden v. Feiden* involved the question of whether a party, diagnosed with Alzheimer's disease, was competent to convey real estate and the court held that the burden of proving incompetence was on the party asserting it. [5] *In re Obermeier* once again involved a real estate sale; this time the seller was allegedly "confused" at the time she executed the contract; once again the court held that the burden of proof was on the one asserting that the party was not competent at the time of the transaction.[6] In *In re Waldron,* the issue was whether an individual with Alzheimer's disease was competent to add a joint tenant to his bank account: the *Waldron* court did not shift the burden of proof or impose a higher evidentiary standard on the proponent of the transaction.[7]

Hubbard v. Gatz, also involving the conveyance of real estate, was the only reported case cited by the *Martin* court that held that the burden of proof shifted upon the showing of mental illness or defect and that the burden had to be met by clear and convincing evidence.[8] In all of the other cases cited by the said court, the burden remained on the party asserting that the seller was incompetent at the time of transaction despite the alleged mental illness or defect of the party executing the document.

Interestingly, the *Martin* court did not discuss why, in light of the presumption of competence of PHL § 2981(1)(b), a showing of mental illness or defect would shift the burden of proof so dramatically. Furthermore, it is respectfully submitted that the said court's holding flies in the face of *Rivers v. Katz*: this seminal case emphatically held that a mentally ill person had the right to refuse medication to control his or her illness unless the state showed by clear and convincing evidence that the patient was not able to make a reasoned decision about the proposed treatment.[9]

It is respectfully submitted that the reasoning in *Rivers v. Katz* equally applies to the issue of whether a person has capacity to execute a health care proxy.

> It is a firmly established principle of the common law of New York that every individual "of adult years and sound mind has a right to determine what shall be done with his own body" *(Schloendorff v Society of N.Y. Hosp.,* 211 N.Y. 125, 129 [Cardozo, J.]) and to control the course of his medical treatment *(see, Matter of Storar,* 52 N.Y.2d 363; *Schloendorff v Society of N Y Hosp.,* 211 N.Y. 125, *supra).* This tenet has been faithfully adhered to by our courts *(see, Matter of Storar,* 52 N.Y.2d 363, *supra; Matter of Harry M.,* 96 A.D.2d 201, 207; *see generally, People v Eulo,* 63 N.Y.2d 341, 357; *Hanes v Ambrose,* 80 A.D.2d 963; *Matter of Saunders v State of New York,* 129 Misc.2d 45, 50; *Matter of Winthrop Univ. Hosp. v Hess,* 128 Misc.2d 804; *Matter of Erickson v Dilgard,* 44 Misc.2d 27 [Meyer, J.]), and recognized by our Legislature (Public Health Law §§ 2504, 2805-d; CPLR 4401-a N.Y.C.P.L.R; 10 N.Y.C.R.R. 405.25 [a] [7]).
>
> In *Storar,* we recognized that a patient's right to determine the course of his medical treatment was paramount to what might otherwise be the doctor's obligation to provide medical care, and that the right of a competent adult to refuse medical treatment must be honored, even though the recommended treatment may be beneficial or even necessary to preserve the patient's life (52 N.Y.2d, at p 377, *supra).* This fundamental common-law right is coextensive with the patient's liberty interest protected by the due process clause of our State Constitution *(cf. Cooper v Morin,* 49 N.Y.2d 69, 80).
>
> In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires *(see, Matter of Erickson v Dilgard,* 44 Misc.2d 27, 28, *supra; see generally, Olmstead v United States,* 277 U.S. 438, 478 [Brandeis, J., dissenting]; *Union Pac. Ry. Co. v Botsford,* 141 U.S. 250, 251; *Davis v Hubbard,* 506 F. Supp. 915, 930-933; *Pratt v Davis,* 118 Ill. App. 161, 166, *affd* 224 Ill. 300, 79 N.E. 562). This right extends equally to mentally ill persons who are not to be treated as persons of lesser status or dignity because of their illness *(Superintendent of Belchertown State School v Saikewicz* 373 Mass. 728, 370 N.E.2d 417). As noted by the Supreme Court of Oklahoma, "[i]f the law recognizes the right of an individual to make decisions about * * * life out of respect for the dignity and autonomy of the individual, that interest is no less significant when the individual is mentally or physically ill" *(Matter of K.K.B.,* 609 P.2d 747, 752).
>
> In delineating their interest in medicating certain patients over their objections, respondents do not dispute the right of competent adults to control the course of their treatment and to refuse antipsychotic medication, but argue that an involuntarily committed mental patient is presumptively incompetent to exercise this right since in ordering involuntary retention, the court has implicitly determined that the patient's illness has so impaired his judgment as to render him incapable of making decisions regarding treatment and care.

> We conclude however, that neither the fact that appellants are mentally ill nor that they have been involuntarily committed, without more, constitutes a sufficient basis to conclude that they lack the mental capacity to comprehend the consequences of their decision to refuse medication that poses a significant risk to their physical well-being. Indeed, it is well accepted that mental illness often strikes only limited areas of functioning, leaving other areas unimpaired, and consequently, that many mentally ill persons retain the capacity to function in a competent manner *(see*, Brooks, *Constitutional Right to Refuse Antipsychotic Medications*, 8 Bull of Am Academy of Psychiatry & L 179, 191 [hereafter cited as *Constitutional Right]; Rogers v Okin*, 478 F. Supp. 1342, 1361). Nor does the fact of mental illness result in the forfeiture of a person's civil rights *(see*, Mental Hygiene Law § 33.01), including the fundamental right to make decisions concerning one's own body *(see*, Du Bose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment*, 60 Minn L Rev 1149, 1160).[10]

The Court went on to say:

> We reject any argument that the mere fact that appellants are mentally ill reduces in any manner their fundamental liberty interest to reject antipsychotic medication. We likewise reject any argument that involuntarily committed patients lose their liberty interest in avoiding the unwanted administration of antipsychotic medication. We recognize, however, that the right to reject treatment with antipsychotic medication is not absolute and under certain circumstances may have to yield to compelling State interests *(Matter of Storar*, 52 N.Y.2d 363, 377, *supra; see, Matter of Eichner*, 73 A.D.2d 431, *mod* 52 N.Y.2d 363; *see, e.g., People v Onofre*, 51 N.Y.2d 476). Where the patient presents a danger to himself or other members of society or engages in dangerous or potentially destructive conduct within the institution, the State may be warranted, in the exercise of its police power, in administering antipsychotic medication over the patient's objections [http://www.loislaw.com/pns] *(Addington v Texas*, 441 U.S. 418, 426; *see, Davis v Hubbard*, 506 F. Supp. 915, 934-935, *supra; People v Medina*, Page 496 705 P.2d 961, 971 [Col]; *Matter of K.K.B.*, 609 P.2d 747, 751 [Okla], *supra; Gundy v Pauley*, 619 S.W.2d 730 , 731 [Ky] [electroshock therapy]; Note, *Common Law Remedy, op. cit.*, 82 Colum L Rev, at 1738-1743).[11]

It is respectfully submitted that the right to make health care decisions is a fundamental right of the patient protected by the due process clause of the state Constitution, statute and case law. This right should not be infringed upon unless there is a showing by clear and convincing evidence that the patient does not have the ability to understand the nature and consequences of his or her health care decisions. The burden of proof should be on the party attempting to assert that the individual was incompetent when he made the health care decision. Since appointing a health care agent is a part of the health care decision making process, the aforesaid principles should apply to the determination of capacity to execute a health care proxy.

Endnotes

1. 293 A.D.2d 619, 620, 741 N.Y.S.2d 84 (2d Dep't 2002). This was the only reported case the author found on the issue of capacity to execute a health care proxy.
2. Many of these cases were cited by the *Martin* court.
3. I did not review *In re Shapiro*, N.Y.L.J., Apr. 19, 2001, at 25, col 1.
4. 173 A.D.2d 535, 570 N.Y.S.2d 135 (2d Dep't 1991).
5. 151 A.D.2d 889, 542 N.Y.S.2d 860 (3d Dep't 1989).
6. 150 A.D.2d 863, 540 N.Y.S.2d 613 (3d Dep't 1989).
7. 240 A.D.2d 507, 659 N.Y.S.2d 290 (2d Dep't 1997).
8. 130 A.D.2d 622, __ N.Y.S.2d __ (2d Dep't 1987).
9. 67 N.Y.2d 485, 497, 504 N.Y.S.2d 74 (1986).
10. *Id.* at 492-494.
11. *Id.* at 495-496.

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National Case News

Professional Responsibility: The Attorney as Fiduciary or Beneficiary

By Steven M. Ratner

Introduction

In my Summer 2003 column, I addressed two recent cases[1] from the state of Maryland where the state grievance commission indefinitely suspended two attorneys from the practice of law for drafting wills that contained gifts to themselves. These recent cases illustrate the importance of understanding and closely following the ethical rules that apply to the fairly common scenario where an attorney is asked to serve as a fiduciary under a will, and the less common scenario where a client seeks to make a gift to a lawyer under an instrument drafted by the lawyer. This article first addresses the rules that apply to the attorney as fiduciary and then the rules that apply to the attorney as beneficiary.

The Attorney as Fiduciary

It is a fairly common occurrence for a client to request that a lawyer serve as a fiduciary under an instrument drafted by the lawyer. Before accepting such nomination, the lawyer should be aware of the relevant ethical and statutory rules. Ethical Consideration 5-6 of the Code of Professional Responsibility provides: "A lawyer should not consciously influence a client to name the lawyer as executor, trustee, or lawyer in an instrument. In those cases where a client wishes to name the lawyer as such, care should be taken by the lawyer to avoid even the appearance of impropriety."

The terms "consciously influence" and "avoid even the appearance of impropriety" are vague and provide little guidance. The Appellate Division, Second Department case, *In re Corya*,[2] provides some guidance on this issue. In that case, the court wrote that "courts may interfere with a testator's manifested intention and exclude an executor only where the evidence warrants an affirmative finding of impropriety and overreaching."

In addition to following EC 5-6, an attorney must also comply with SCPA 2307-a if he or she is to receive a full commission. SCPA 2307-a provides that when an attorney prepares a will to be proved in New York and such attorney or a then affiliated attorney is an executor-designee, the testator must be informed prior to executing the will that:

> Subject to limited statutory exceptions, any person, including an attorney, is eligible to serve as an executor;
>
> absent an agreement to the contrary, any person, including an attorney, who serves as an executor is entitled to receive an executor's statutory commission; and
>
> if such attorney or an affiliated attorney renders legal services in connection with the executor's official duties, such attorney or then affiliated attorney is entitled to receive just and reasonable compensation for such legal services, in addition to the executor's statutory commission.

An acknowledgment of disclosure by the testator must be set forth in writing and signed by the testator in the presence of at least one witness.

The statute sets forth a model form for the acknowledgment of disclosure. In the absence of such disclosure, the attorney-executor is entitled to one-half the normal statutory fee for serving as executor. Section 2307-a applies to a will executed on or after January 1, 1996, and irrespective of the date of any will, to estates of decedents dying after December 31, 1996.

Compliance with section 2307-a is determined upon the filing of the petition to probate a will. Question 1(b) on the uniform Petition for Probate asks whether the proposed executor is an attorney. In addition, where a person seeking letters to administer an estate as sole executor or administrator is also an attorney admitted in New York, he or she must disclose: (1) that the fiduciary is an attorney, (2) whether the attorney or her firm will act as counsel, and (3) if applicable, whether the attorney drafted the will offered for probate.[3] In practice, the local Surrogate's Courts often require this statement even where the attorney is serving as co-executor.

An attorney asked to serve as an executor should exercise care to follow both the letter and spirit of these rules. An attorney would be well-advised to avoid accepting designation as an executor for a client with whom the attorney has no preexisting relationship. Even where such a relationship does

exist, the lawyer should suggest that the client consider other individuals to serve as executor.

In those cases where the lawyer concludes that it is appropriate to serve as executor, the lawyer may wish to protect herself by asking the client to write a short note to the lawyer requesting that the lawyer serve as executor and giving reasons for the client's decision.

An attorney should also consider the practical consequences of serving as executor. Does the attorney really want to take on the responsibility of marshalling the decedent's assets and sorting and safekeeping the decedent's personal effects and other property? An attorney's time might be better spent serving as the lawyer for the estate and having a family member or friend take on the role of executor.

The Attorney as Beneficiary

A lawyer should never accept a gift from a client unless the client is first referred to an independent lawyer. EC 5-5 provides:

> A lawyer should not suggest to the client that a gift be made to the lawyer or for the lawyer's benefit. If a lawyer accepts a gift from a client, the lawyer is peculiarly susceptible to the charge that he or she unduly influenced or overreached the client. If a client voluntarily offers to make a gift to the lawyer, the lawyer may accept the gift, but before doing so, should urge the client to secure disinterested advice from an independent, competent person, who is cognizant of all the circumstances. Other than in exceptional circumstances, the lawyer should insist that an instrument in which the client desires to name the lawyer beneficially be prepared by another lawyer selected by the client.

Note that where a client seeks to make an attorney a beneficiary under a will, the client must seek independent counsel from a lawyer selected by the client, not the lawyer.

Question 8(a) of the uniform Probate Petition expressly asks whether any person entitled to receive citation or notice of probate had a confidential relationship with the decedent as an attorney. If the answer to this question is yes, an explanatory affidavit must be submitted with the Petition (commonly known as a *Putnam* affidavit).[4]

Conclusion

Both the *Stein* and *Brooke* cases illustrate that a lawyer can face serious discipline if the lawyer drafts a will leaving a bequest to herself. In addition, a lawyer may be subject to discipline if he or she unduly influences a client to name the lawyer as a fiduciary under a will or trust. For this reason, a lawyer should exercise care to follow the above noted rules and should have the client seek independent legal advice in appropriate cases.

Endnotes

1. *Attorney Grievance Commission of Maryland v. Charles F. Stein III*, Md. Ct. App., Mar. 18, 2003 and *Attorney Grievance Commission of Maryland v. John A. Brooke,* Md. Ct. App., Apr. 11, 2003.
2. 175 A.D.2d 162, 572 N.Y.S.2d 51, 52 (2d Dep't 1991).
3. 22 N.Y.C.R.R. § 207.17.
4. *See In re Putnam*, 257 N.Y. 140 (1931) ("Attorneys for clients who intend to leave them or their families a bequest would do well to have the will drawn by some other lawyer. . . . The law, recognizing the delicacy of the situation, requires the lawyer who drafts himself a bequest to explain the circumstances and to show in the first instance that the gift was freely and willingly made.").

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

Mr. Ratner's work experience includes a one-year clerkship with the Honorable Herbert Y.C. Choy of the United States Court of Appeals for the Ninth Circuit in Honolulu, Hawaii. Mr. Ratner was formerly an Adjunct Professor of Taxation at Golden Gate University in Los Angeles.

Stephanie Leb, a second-year law student at New York Law School, assisted with the preparation of this article.

Snowbird News

Special Needs Trust Planning in Florida

Florida Sunshine for the New York Elder Law Attorney

By Scott M. Solkoff

Usage of Special Needs Trusts and Agency Action

1. Difference between pooled and individual trusts
2. Differing models of pooled trusts
3. Using the third party individual trust as an elective share shelter
4. SSA Atlanta Regional ruling on annuities
5. Using the pooled trust as another ICP planning option

Though special needs trusts originate in federal law, elder law attorneys are aware of tremendous state variation in trust usage and acceptance. This article is designed to increase the New York attorney's awareness of how special needs trusts are being deployed and treated in Florida.

Usage of Special Needs Trusts in Florida and Agency Action: Individual and pooled special needs trusts are increasingly being used as tools in Florida, not only for the under-65 disability community but for the infirm elderly as well. Negative agency action is rare but is happening with greater frequency as the trusts are used more and more. The state of Florida delegates Medicaid financial eligibility determination to the Florida Department of Children and Families (DeCaF). DeCaF case workers are generally overworked, undertrained, underpaid and not very interested in learning about special needs trusts. It is uncommon for DeCaF to deny eligibility on special needs trusts partly because their computer systems detail key trust requirements and, so long as those requirements are found, they move on. We once mistakenly provided DeCaF with a special needs trust that was missing six pages. It was approved because the required language appeared on the other pages (never mind the fact that those six pages should have been extremely relevant to any determination). Denials are, however, becoming more frequent both from DeCaF and more usually from the Social Security Administration (SSA). Some recent grounds for denial from the SSA Regional Office in Atlanta:

(1) The trusts should designate heirs with great specificity. "To my heirs" or similar language is not acceptable to SSA. My office had difficulty with language which mirrored the Florida intestacy code, but we ultimately prevailed on that issue.

(2) Structured settlement annuities: There has been recent adverse SSA action stating that annuity payments paid into a special needs trust (D4A) will be counted as income to the disabled beneficiary. Since this decision has far-reaching implications for settlement protection planning, it is being closely watched on appeal.

(3) The trusts cannot have powers of appointment. This is becoming a more common but wholly inappropriate grounds for denial.

(4) Pooled trusts must offer a payback provision to the government. Denials based on this ground have not yet succeeded in Florida.

Differing Models of Pooled Trusts: In Florida, there are four active pooled special needs trusts, including one of the largest in the nation. The trusts work from different models and are administered differently. One Florida pooled trust is a not-for-profit that provides no services other than service as trustee of its pooled trust. The other pooled trusts have existing not-for-profits as trustees. Some of the trusts retain 100% of any monies remaining on the disabled beneficiary's death without any repayment to the government. Other of the trusts repay the government for medical assistance provided to the disabled beneficiary and then split any remainder with named beneficiaries. The administrative costs of the trusts run from 1% to 3.5% depending on what services are provided and how the funds are invested. One of the pooled trusts I set up has the retained monies being used to fund public guardianship. Another of the trusts has endowed an Elder Law Chair with its retained funds. There are innovative uses of pooled trusts and these choices will be expanding in Florida (and in New York as well).

Using Special Needs Trusts as an Elective Share Shelter: Florida now has an augmented elective share estate. To defeat elective share in Florida, it used to be as easy as funding a trust or using almost any other probate avoidance tool. Now, the elective estate is quite inclusive and this creates Medicaid planning issues. If the well spouse predeceases the ill spouse, the ill spouse could become entitled to an inheritance that will disqualify the ill spouse from Medicaid. Failure to elect a share of the decedent's estate will subject the institutionalized spouse to a period of ineligibility as if the elective share amount were gifted away. The solution? An elective share special needs trust, of course! If a third-party testamentary special needs trust is funded with the elective share, it is counted dollar for dollar toward satisfaction of the elective share but it cannot be counted toward the beneficiary's Medicaid eligibility.

Using Pooled Trusts as a Medicaid Planning Option: For a single person over the age of 65, the planning options are much more limited in Florida than for a married couple. In Florida (as it should be in New York), enrollment in a pooled trust is a very efficient and effective method of qualifying a single person for Medicaid. As a sole benefit trust, the trustee can use the money only for the elder and only to supplement the need-based benefits. A child could be paid out of the trust as a caregiver. If there are monies left over upon the beneficiary's death, depending on the arrangement with the trustee, the family may still inherit monies with satisfaction of any Medicaid pay-back. This is a quick planning option that can be implemented before the end of the qualifying month. Because it is a D4C pooled trust, the disabled beneficiary can himself or herself enroll without court involvement.

Special needs trusts are being increasingly utilized in Florida. Unfortunately, as the trusts become more common, the government is also becoming more vigorous in creating eligibility traps. I hope this article has been helpful to you.

Fourth in a series of articles by Scott Solkoff relating to the New York Floridian. Scott M. Solkoff is a Florida Bar board-certified specialist in elder law primarily serving clients in southeast Florida. If you have requests for future installments or should you have any questions or comments, the author may be reached at (954) 765-1035 or (561) 733-4242.

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Mediation News

By Robert A. Grey

Welcome to the new Elder Law Mediation News feature! We actively solicit your mediation questions, comments and experiences, positive or negative. Please send them to Robert A. Grey, Esq., 38 Stiles Drive, Melville, NY 11747-1016 or rgrey@justice.com. Author's note: Some quotations used in this article refer to the male gender only. It is this author's express intent that they be read as applying equally to women.

> **The notion that most people want black-robed judges, well-dressed lawyers and fine paneled courtrooms as the setting to resolve their disputes is not correct. People with problems, like people with pains, want relief, and they want it as quickly and inexpensively as possible.**[1]

Chief Justice Burger's quote is particularly true for the elder law practitioner, who is often thrust into a situation of physical, mental, emotional and financial *extremis*. Mediation is a valuable tool in any attorney's or judge's toolbox. It gives clients/parties what they want and AIPs what they need: creative, timely and relatively inexpensive solutions to their problems.

In April 2002, the Advisory Committee on Civil Practice to the Chief Administrative Judge of the Courts of the State of New York made a number of recommendations to expand the use of alternative dispute resolution (ADR), with an emphasis on mediation. In recommending the "Enactment of a Comprehensive Court-Annexed Alternative Dispute Resolution Program," the Committee found that

> ADR has become a growing force around the country and indeed around the world. Court systems have explored ADR in recognition of the imperative to find means by which to ensure swift, efficient and inexpensive justice for civil litigants at a time of large caseloads, limited judicial resources, and rapidly escalating legal costs. Judges in this State typically carry very large civil caseloads. The demands upon the judges' time are great. The expense of litigation is significant and unlikely to decline. Court-annexed ADR offers an opportunity for the achievement by the court system of swift, efficient and inexpensive resolution of some matters, while freeing up judicial time that can be expended on matters that really must be tried to a conclusion.[2]

As this issue of the *Elder Law Attorney* goes to press, the Office of Court Administration (OCA) has a committee preparing a two-county pilot project to implement mediation in MHL Article 81 proceedings. Charles Devlin, Esq., the OCA statewide Director of Guardian and Fiduciary Services, and Marita McMahon, Esq., Deputy Director, informed the author that although the details have yet to be determined, under the pilot project it is likely that all Article 81 guardianship cases will be screened for issues amenable to mediation, and all contested cases will be mandated for at least one mediation session. If successful the project will be rolled out to other counties or statewide.[3]

> **Discourage litigation. Persuade your neighbors to compromise whenever you can. Point out to them how the nominal winner is often a real loser—in fees, expenses and waste of time. As a peacemaker the lawyer has superior opportunity of being a good man. There will still be business enough.**
>
> **—Abraham Lincoln (1850)**

There will always be cases, including Article 81 cases, that will be need to be litigated. Mediation is not a panacea. However, there are many cases which can be resolved with the help of a mediator, at any stage of a case, be it pre-litigation or during litigation. Mediation is even used successfully in appellate practice.

Consequently, attorneys should not fear the introduction of mediation into Article 81 practice, nor should they fear the mediation process itself. A confident and effective mediator welcomes the participation of attorneys along with their clients at the mediation table. In mediation, attorneys are a resource for their client and can assist in devising creative solutions. Mediation sessions often generate a collaborative "win-win" atmosphere, where all parties can

leave as winners, rather than an acrimonious "win-lose" result. While the focus in mediation is on the clients, attorneys are justified in billing for their time at the mediation table and preparation for each session.

> **It is generally better to deal by speech than by letter; and by the mediation of a third than by a man's self.**
>
> **—Sir Francis Bacon (1561-1626)**

Although the term "mediation" has been around for hundreds of years, it is widely misunderstood and misused. Even authoritative dictionaries have significantly differing definitions. An accurate and concise definition is:

> The intervention into a dispute or negotiation by an acceptable, impartial, and neutral third party, who has no authoritative decision-making power, to assist disputing parties in voluntarily reaching their own mutually acceptable settlement of the issues in dispute.[4]

Our own Office of Court Administration offers a more expanded definition:

> A consensual dispute resolution process in which a neutral third party helps disputants to identify issues, clarify perceptions and explore options for a mutually acceptable outcome. In general, mediators do not offer their own opinions regarding likely court outcomes or the merits of the case. Instead, mediators offer the opportunity to expand the settlement discussion beyond the legal issues in dispute and focus on developing creative solutions, which emphasize the parties' practical concerns.[5]

Mediation is a voluntary, informal process. One may reasonably ask how court-mandated mediation can be considered voluntary. The answer is that what is mandated is the appearance of the parties and their counsel, and their good-faith participation in the mediation session(s). Reaching agreement during mediation remains entirely voluntary.

Mediators do not have any power or authority whatsoever to impose settlement on the parties. They do not take testimony or evidence, and have absolutely no power to make factual determinations, legal rulings or issue any decisions, be they procedural, final or interlocutory. Rather, the mediator's role is to help the parties reach their own voluntary resolution through discussion and negotiation.

A critical feature of mediation is confidentiality. Frank and open discussion is promoted by the knowledge that nothing said in mediation will be used in any other forum. Whether by written agreement, statute or rule, mediation sessions are confidential and no transcript or recording is produced. Emotions, perceptions and non-legal issues are considered important in the mediation process, and participants are not likely to discuss them if they believe what is said in mediation may be revealed in court. The mere use or discussion of evidence in mediation does not shield that evidence from later use just because it was used or discussed in mediation.

Conclusion

There is no doubt that ADR, particularly mediation, will be impacting the practice of elder law in New York in the near future. The aim of this article is to give the reader a brief introduction to mediation. In future articles, this column will strive to provide more detailed information to assist the elder law practitioner in understanding, utilizing and benefiting from the mediation process.

Mediation offers the promise of enabling parties to voluntarily reach mutually satisfactory terms in resolving their disputes. Attorneys can and should be an integral part of the process. Mediation is well suited for use in estate planning, probate, and trusts and estate practices, not just in guardianship matters. The author encourages every elder law attorney to seriously consider how mediation can positively influence their practice of elder law.

Endnotes

1. Chief Justice Warren E. Burger, *Our Vicious Legal Spiral*, 16 Judges J. Vol. 22, No. 49 (Fall 1977).
2. *2002 Report of the Advisory Committee on Civil Practice to the Chief Administrative Judge of the Courts of the State of New York*, McKinney's Session Law News of New York No. 1, A-33 (April 2002).
3. Discussion with Charles Devlin, Esq., Director of Guardian and Fiduciary Services, and Marita McMahon, Esq., Deputy Director (June 24, 2003).
4. Moore, C. W., The Mediation Process, 14 (Jossey-Bass, 1986), as adapted in Hartman, S., *Adult Guardianship Mediation Manual*, The Center for Social Gerontology, 2002, Module 1, p. 8.
5. New York State Unified Court System (OCA) Office of Alternative Dispute Resolution Programs Web site (http://courts.state.ny.us/adr/Mediation%20Definition.htm).

Robert A. Grey, Esq. maintains a practice in Melville, Long Island, New York, with an emphasis on providing alternative dispute resolution (ADR), particularly mediation and arbitration, in areas such as elder law, trusts and estates, probate, family, matrimonial, commercial, e-commerce, construction, labor, employment, disability and discrimination disputes. He is admitted to practice in New York, Washington, D.C., the Federal Eastern and Southern Districts of New York, and the United States Supreme Court. His practice serves the entire New York City metro area including Long Island and the lower Hudson Valley.

Mr. Grey has experience as a guardian, court evaluator, guardian ad litem and attorney for AIP in guardianship proceedings. He is the author of the chapter on Mediation in Guardianship Practice in the upcoming NYSBA *Guardianship Practice in New York State, 2nd Edition*, and has given presentations on mediation to various law school, bar association and community groups. He is a member of the NYSBA Elder Law Section, NYSBA ADR Committee, Suffolk County Bar Association Elder Law Committee, Queens County Bar Association Elderly and the Disabled Committee, and the National Association of Elder Law Attorneys (NAELA).

Robert A. Grey earned his J.D. degree from New York Law School in 1985, where he was a John Ben Snow Scholar, and his B.A. degree in Economics with an Adjunct in Business Management from the State University of New York (SUNY) at Binghamton in 1982, where he was a member of the International Economics Honor Society (calculation of GPAs and awarding of official Honors were against University policy).

He is also a founding member and Deputy Managing Attorney of the NYPD Legal Bureau Civil Enforcement Unit. In 1995 this unit was a recipient of the Innovations in American Government Award of the Ford Foundation, administered by the John F. Kennedy School of Government at Harvard University for its achievements in furtherance of the NYPD's Civil Enforcement Initiative. He is an 18-year veteran of the NYPD having been sworn in as a Police Officer in 1986, promoted to Detective in 1991, and to his current rank of Sergeant in 1992.

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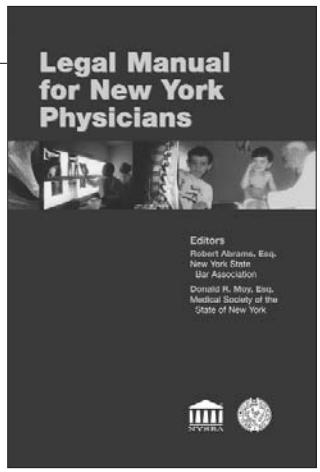

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