NYSBA SUMMER 2004 | VOLUME 25 | NO. 1

ONEONONE

A publication of the General Practice Section
of the New York State Bar Association

Message from the Chair

The General Practice Section is currently confronting very challenging issues regarding how to most effectively meet our members needs and concerns in the practice of law. After a great deal of study, reflection and dialogue, the section leadership has decided to focus its efforts and resources towards providing information and services that focus on four major areas: ***Law Practice and Management, Ethics and Professionalism, Technology, and Leadership and Development.***

Law Practice and Management

Many solo and small-firm practitioners require information on how to most effectively develop and operate their practices. Practitioners struggle with balancing efficiency with quality of life. Many are also concerned with acquiring appropriate life, health, disability and liability insurance. Practitioners are also concerned with providing quality legal services in a cost-effective manner. The Section will be devoting considerable resources in conjunction with the New York State Bar Association in the area of Law Practice and Management. Of course we will continue to provide valuable substantive legal information to general practitioners.

Ethics and Professionalism

Many practitioners are concerned about the growing need to maintain high standards of professionalism and ethical behavior in a climate of increased financial pressure and a lack of growing civility among colleagues. The General Practice Section is dedicated to providing the most current information regarding ethics and professionalism in the practice of law. Through Section publications, we will provide important case decisions as well as case analysis regarding ethics. We will also provide helpful information on how to avoid problems involving professionalism.

Technology

The use of technology has become another challenging aspect of the practice of law. What technology is appropriate for the solo and small-firm practitioner? How do we use the technology most efficiently? How can we avoid the purchase and use of inappropriate technology in our practices? Solo and small-firm practitioners have many questions and concerns regarding the integration of technology into their practices. The General Practice Section will begin to assist members in navigating through the complex maze of technology and technology products.

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Leadership and Development

Finally, the General Practice Section will begin to assist members in acquiring and developing the skills necessary to be effective leaders in the profession and in the community. Many practitioners—particularly women, minorities and new lawyers—have a great desire to serve as leaders in the Bar and in their communities but lack the skills and the mentoring to succeed. In order to be an effective leader, certain skills must be developed and even perfected. The General Practice Section will be developing a program to help solo and small-firm practitioners, particularly, women, minorities and new lawyers, develop the skills necessary to serve as effective Bar and Community Leaders. In this regard a Leadership Development Program will be created and implemented in the near future. We invite the feedback of our members and certainly their participation in this new and exciting program.

Summary

The General Practice Section is committed to developing Leadership within the Section that is representative of the profession at large. We are also dedicated to providing current and relevant information in order for our members to effectively practice law and deliver quality legal services to the general public. In order to accomplish this goal, we would like to see an increase in the involvement of women, minorities and new lawyers in the leadership of the General Practice Section.

Anyone interested in becoming involved can contact me at (516) 742-7601 or at fgdangeloesq@aol.com.

Frank G. D'Angelo

From the Editor

This summer edition of *One on One* discusses some interesting areas which we have not addressed for some time. I don't remember the last time we did a piece on Elder Law, so we have included an interesting comprehensive article on what all attorneys should know about Elder Law.

We are also including an article on an important area of matrimonial law dealing with relocation of a spouse and child, particularly where the relocation is expected to be permanent.

Of course, there is again the column on workers' compensation hot issues, which in this edition involves parental responsibilities and rights acquired under the Workers' Compensation Law, when a child dies in an accident which arises out of and in the course of an employment.

Those who have wondered about what State Insurance Guaranty Funds are about, you may find the article on that topic to be of interest and enlightening.

As always, we are looking forward to seeing articles from our membership. Please try to share your expertise with the rest of us; jot down 1,000 words or so and forward them on to us.

Enjoy the summer!

Martin Minkowitz
Co-Editor

REQUEST FOR ARTICLES

If you have written an article, or have an idea for one, please contact *One on One* Co-Editor:

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

What All Attorneys Should Know About Elder Law

By Anthony J. Enea

It has been estimated that within the next four years some 70 million "baby boomers" will reach retirement age. Inevitably, attorneys will be asked by their clients to address elder law issues with ever-increasing frequency. Whether it be questions about long-term care insurance policies, life care communities, assisted living facilities, home care, Medicaid eligibility, guardianships or any other of the numerous issues that will affect the "baby boomers," one thing is certain: having a basic understanding of elder law will be of critical importance.

Although the practice of elder law encompasses many diverse areas of law, asset protection planning and Medicaid eligibility continue to remain its core components. Unfortunately, it is within these components of the practice of elder law that a number of misconceptions occur.

Distinctions Between Medicare and Medicaid

As a starting point, it is important to know the distinctions between Medicare and Medicaid. Briefly, Medicare is a federal program which is available to persons who are 65 years of age and older, as well as certain disabled persons. Presently, Medicare provides health care for approximately 40 million elderly and disabled Americans. Since the passage of Title XVII of the Social Security Act in 1965, Medicare has basically been the health insurance component of Social Security.[1] Medicare provides health insurance for those 65 years of age and older *without* any asset or income requirements. The Medicare program is administered by the federal government.

There are three separate components of Medicare:

Medicare Part A—covers the costs of in-patient hospital care, home health care, hospice care and some "skilled" nursing care. The hospital care must be determined to have been medically necessary.[2]

Medicare Part B—covers part of the cost of physician services and other medical services and supplies. For example, if an individual is hospitalized, the hospital bill would be covered by Part A; however, the patient's physician services would be covered by Medicare Part B.[3]

Medicare Part C (Medicare Plus Choice)—this portion of Medicare was enacted to provide those eligible for Medicare to have the option of having physicians' services provided to them by various health care providers such as HMOs.[4]

For purposes of nursing home planning, it is important to remember that Medicare only covers a maximum stay in a skilled nursing facility for 100 days, if the admission to the nursing home is within 30 days of the hospital discharge.[5] The patient must require skilled nursing or skilled rehabilitative services on a daily basis.[6] Of said 100 days, Medicare will cover the first 20 days in full, and for the next 80 days Medicare will pay everything except $109.50 per day. Medicare does not provide any coverage for custodial care, which is generally most of the care a nursing home patient receives. This is where the need for Medicaid eligibility is of importance.

"Whether it be questions about long-term care insurance policies, life care communities, assisted living facilities, home care, Medicaid eligibility, guardianships or any other of the numerous issues that will affect the 'baby boomers,' one thing is certain: having a basic understanding of elder law will be of critical importance."

Medicare Prescription Drug Program

In November 2003, Congress passed a Medicare reform bill which contained as one of its principal components a new prescription drug benefit. Commencing in 2006, Medicare will pay three-quarters of a senior's prescription drug costs up to $2,250, at which point the coverage would cease until out-of-pocket costs reach $3,600. Above the $3,600 amount Medicare would pay for approximately 95% of the cost. In order to obtain this benefit, seniors will be required to pay $35 per month for the first year and a $200 annual deductible.

Until the new drug benefit becomes effective in 2006, low-income seniors will receive a prescription drug discount card that they can use. The bill also eliminates restrictions contained on tax-sheltered medical savings accounts and creates tax-preferred health savings accounts which will be available to all Americans.

Medicaid

Unlike Medicare, Medicaid, which was enacted in 1964 by Title XIX of the Social Security Act, is a "means tested" entitlement program which is jointly adminis-

tered by the federal and state governments. As a "means tested" entitlement program, Medicaid has income and resource limits as a precondition to eligibility. In order to participate in the Medicaid program, in 1965 New York State enacted the enabling legislation to effectuate the availability of Medicaid in New York.[7]

In addition to the income and resource requirements for eligibility for Medicaid, residency is an additional prerequisite to eligibility. For purposes of Medicaid eligibility, residency is defined as the location where the applicant has a permanent home.[8] Generally, to be eligible for Medicaid in New York, an individual must be a resident of the state.[9] Although New York has no durational residency requirement, it still is necessary that the individual applicant be a resident of New York.[10] The physical presence within the state and the intent to remain are all critical factors in establishing residency.[11] Although it is not necessary that one be a citizen, it is necessary that one be a legal resident.[12]

Finally, to be eligible for Medicaid it is necessary that an individual be under the age of 21 or over the age of 65.[13] Those between the ages of 21 and 65 can become eligible for Medicaid only if they are blind, disabled, eligible for public assistance, or recipients of Supplemental Security Income.[14]

Income and Resource Requirements for Nursing Home Medicaid Eligibility

For purposes of this article, I will focus on eligibility for Medicaid for institutional services in New York State, which, most importantly, includes nursing homes. There are also categories of Medicaid coverage for home care services as well as community Medicaid. One long-term home health care program, commonly referred to as the "Lombardi Program" or "Nursing Home Without Walls," has essentially the same financial eligibility requirements as nursing home Medicaid.

An applicant for nursing home Medicaid must have income and resources below specified amounts.[15] If the applicant for nursing home Medicaid is single, his or her monthly income in excess of fifty ($50) dollars ("personal needs allowance") must be paid to the nursing home.[16] In addition to the aforestated fifty dollars ($50) per month of income, the applicant for Medicaid is permitted to have $3,950 in resources, known as a "luxury fund," for the year 2004. Resources are defined as property of any kind, whether real property, tangible or intangible, liquid or non-liquid. Administrative Directive: 96 ADM-8 of the New York State Department of Social Services provides that assets for purposes of Medicaid eligibility are defined as all of the individual's and spouse's income and resources. However, there are exceptions which I will discuss later. For a married couple who are both seeking eligibility for nursing home Medicaid, the combined resource allowance is $5,700 in the year 2004. Both the income and resource requirements are uniform throughout the entire state of New York.[17]

As can be seen from the above, one who is single can have neither a significant amount of income nor resources to satisfy the eligibility requirements for Medicaid. In order to encourage individuals to remain at home as long as possible, rather than entering a nursing home, the income and resource eligibility requirements for the spouse of an applicant for Medicaid are significantly higher than those for an individual applicant. The spouse of an individual who is applying for nursing home Medicaid is referred to as the "community spouse." For the year 2004, the "community spouse" is permitted to have resources that range in amount between $74,820 and $92,760.[18] Thus, if a couple's resources are between $149,640 and $185,520, the allowance permitted will be one half of the combined resources. If the combined resources exceed $185,520, the $92,760 resource limit will be applied. If the resources exceed the community spouse's resource allowance ("CSRA"), those excess resources will be subject to a claim by Medicaid to their full extent.[19] Also, the community spouse is permitted to have income not exceeding $2,319 per month. This income allowance is known as the "Minimum Monthly Maintenance Needs Allowance" or "MMMNA."

In discussing the resource allowance for either a single person or for the community spouse, it is important to remember that only non-exempt resources are counted for purposes of Medicaid eligibility.[20] There are resources which are deemed exempt and thus have no effect on eligibility for Medicaid. For example, personal belongings such as clothing, jewelry, automobiles, and other tangible personal property such as the contents of one's home or apartment, are exempt.[21] Most importantly, one's "primary residence," which is referred to as the "homestead" if occupied by the applicant, the applicant's spouse or a minor disabled child, is also an exempt asset for purposes of Medicaid eligibility.[22] The homestead will be considered exempt even if it is a two- or three-family residence, condo or cooperative apartment.[23] If the homestead generates income, the homestead will remain exempt but the income generated is not exempt.[24] If the homestead is occupied solely by the applicant who is applying for nursing home Medicaid, the applicant would need to establish that he or she intends to return home. This is critical in avoiding Medicaid's determination that the occupant is in "permanent absent status," thus, resulting in the homestead losing its exempt status.[25]

Although the homestead is exempt for purposes of eligibility, Medicaid will have a lien against said home-

stead for Medicaid benefits paid for nursing home care or the equivalent thereof.[26] Sections 104 and 369 of the Social Services Law of the state of New York grant to Medicaid the right to recover against the estates of Medicaid recipients and their spouses. Additionally, under the provisions of the Omnibus Budget Reconciliation Act of 1993 ("OBRA 93"), the states were further mandated by the federal government to adopt estate recovery programs.[27]

Transfer of Asset Rules and Medicaid's Lookback Period

On numerous occasions, I have had both clients and colleagues advise me of their belief that all gifts or transfers of assets will automatically disqualify one from Medicaid for three years. This is perhaps the most often repeated misconception that both the public and non-elder law attorneys have about Medicaid eligibility. At times, I believe the "three-year rule" has taken on a life of its own; it's elder law's equivalent of the Miranda warning, often repeated, but rarely understood. Because Medicaid is a "means tested" program, if assets are transferred (gifted) without the receipt of something of equivalent value in return, an "uncompensated transfer" of assets has occurred, which, with a few exceptions which I will discuss later, triggers a period of ineligibility for Medicaid.[28] Calculation of this period of ineligibility is determined by taking the dollar value of the uncompensated transfer of assets and dividing it by the average cost of a nursing home (skilled nursing facility) in the region (county) in which the applicant resides as determined by the Department of Social Services.[29] For example, for the year 2004, the rate for Westchester and other northern metropolitan counties is $7,902 per month. Thus, in Westchester, an uncompensated transfer of $100,000 utilizing the rate of $7,902 per month ($100,000 divided by $7,902) would create a period of ineligibility for Medicaid of approximately 12.66 months. The commencement date of the period of ineligibility is the first day following the month of the transfer.[30] For example, a non-exempt transfer made on September 1st would create a period of ineligibility commencing on October 1st.

With the enactment of OBRA 93, a thirty-six month lookback period was created. Thus, an individual who transfers assets of a high enough value to create an ineligibility period in excess of thirty-six (36) months (for example, $300,000 divided by the Westchester rate of $7,902 creates 37.97 months of ineligibility) can, if that individual waits at least thirty-six months before applying for Medicaid, avoid the longer period of ineligibility (above thirty-six months). However, if one creates an ineligibility period in excess of thirty-six months and does not wait for the thirty-six months to end before applying for Medicaid, he or she would be ineligible for the full period of ineligibility created above the thirty-six months.[31] Thus, it is critical that the application for Medicaid not be filed until the entire period of ineligibility has expired. When applying for Medicaid for nursing home care all transfers of assets made within thirty-six months of the date of filing the application have to be disclosed to the Department of Social Services. In Westchester County the Department of Social Services requests that you provide them with photocopies of all checks, deposits and withdrawals of $3,000 or more with explanations for the last three (3) years.

One important distinction with the Rules for the transfer of assets applies to transfers made to or from an irrevocable lifetime trust. With the enactment of OBRA 93, a sixty-month lookback period was created for transfers made to or from an irrevocable lifetime trust.[32] This sixty-month lookback period has spawned the misconception that all transfers to a lifetime (*inter vivos*) trust will automatically create a sixty-month period of ineligibility and a sixty-month lookback period for Medicaid. If the ineligibility period created by funding the trust (the same formula for outright transfers is used) is less than sixty months, assuming all other income and resource requirements have been satisfied, eligibility would be established when the penalty period ends. For example, if $300,000 is transferred to an irrevocable lifetime trust, the ineligibility period created in Westchester would be 37.97 months. The lookback period for the transfer to the trust, however, is 60 months. If the ineligibility period created is sixty months or more, the applicant will have to wait for the sixty-month period to expire before submitting his or her application for nursing home Medicaid.[33] It should be remembered that all the assets transferred to a revocable lifetime trust, or what is commonly referred to as a "living trust," are considered available for Medicaid purposes and offer no protection for purposes of Medicaid eligibility. The irrevocable income-only trust has established itself as the most commonly used trust for Medicaid asset protection planning. It provides clients with a level of comfort in knowing that they have taken a positive step to protect their assets for purposes of Medicaid eligibility, while allowing them to receive all of the income from those assets. In most instances there is little, if any, change in a client's lifestyle as a result of the creation and funding of said trust.

The transfer of asset rules and the applicable ineligibility periods only apply with respect to applications made for nursing home Medicaid or its equivalent, such as the long-term home health care program available from Medicaid. As previously mentioned, this program is also known as the "Lombardi Program" or the "Nursing Home Without Walls." This program is the only home care program that is affected by a transfer of assets. Thus, any prior transfers that have created periods of ineligibility will also affect eligibility for the Lombardi Program. The spousal impoverishment rules

also apply to the Lombardi Program and "spousal refusal" is also available for the couples that would otherwise be ineligible because of excess resources and/or income. Thus, no ineligibility period is created by any uncompensated transfers for Medicaid home care.

Finally, there are transfers of assets which do not create any periods of ineligibility for nursing home Medicaid. For example, the homestead can be transferred to (a) one's spouse, minor child, disabled or blind child (any age), (b) an adult child who has lived in the home of the parent for at least two years immediately prior to the parents' institutionalization and who has been a caregiver to the parent, and (c) a sibling of the Medicaid applicant who has resided in the home for a least one year prior to institutionalization and who has an equity interest in the home.[34] In addition to the transfer of the homestead, any assets can be transferred without any period of ineligibility being imposed when the transfer is made for the benefit of a spouse or disabled child.[35]

"At this writing, significant changes are in the process of being proposed that would make eligibility for Medicaid even more difficult than it already is."

Spousal Refusal In New York

Typical of the numerous complexities confronting the elder law attorney in New York is Medicaid's "spousal refusal" rule. Medicaid having previously delineated specific financial requirements relevant to the spouse ("community spouse") of the applicant for Medicaid, one would think there would be no way of sidestepping those requirements. However, under New York law, if the spouse of an applicant for Medicaid refuses to pay for the medical expenses of his or her spouse, then the eligibility of the applicant for Medicaid must be determined without giving any consideration to the income and resources of his or her spouse. Thus, once a spousal refusal statement has been filed with Medicaid, irrespective of the income and resources of the applicant's spouse that may be above the Medicaid eligibility levels, Medicaid will not be permitted to consider them.

Although the spouse is permitted to refuse to pay for his or her spouse's medical expenses, the execution of the spousal refusal does not obviate the refusing spouse's liability for Medicaid paid on behalf of his or her spouse. Medicaid can initiate a support proceeding in Family Court against the refusing spouse to recover the actual expenditures made by Medicaid. However, Medicaid's recovery is limited to the community spouse's resources and income in excess of the amount she is permitted to have ("community spouse resource allowance.").[36]

The right to execute a spousal refusal provides the elder law attorney with a significant amount of flexibility in making recommendations to the client. Although Medicaid has in recent years been significantly more aggressive in pursuing reimbursement from the community spouse, there still exists the possibility that Medicaid will not pursue reimbursement. Furthermore, even if reimbursement is pursued, the amount Medicaid can seek reimbursement for is limited to the amount actually expended, and, because Medicaid pays the nursing home a significantly reduced rate for a room versus the rate the applicant as a private pay patient would pay, the execution of a spousal refusal may be a prudent planning choice.

Conclusion

As you can see from the above, even the most basic rules for Medicaid eligibility can be quite complex. Because of its dynamic and continuously changing nature, elder law requires a significant commitment. At this writing, significant changes are in the process of being proposed that would make eligibility for Medicaid even more difficult than it already is. I am hopeful that I have provided the reader with a basic overview of some of its more important components and have helped to eliminate some of its often repeated misconceptions.

Endnotes

1. 42 U.S.C.A. §§ 301–1397e.
2. 42 U.S.C.A. § 1395f(a)(2), 42 C.F.R. §§ 424.5(a)(4), 424.10-13.
3. 42 C.F.R. §§ 410.20, 410.2.2 and 410.23.
4. 42 PL 105-33 § 4001, creating Social Security Act § 1857.
5. 42 C.F.R. § 409.85.
6. 42 C.F.R. § 409.31(b)(1).
7. Soc. Serv. L. § 363.
8. N.Y.C.R.R. § 360-3.2(g).
9. Soc. Serv. L. § 117, 18 N.Y.C.R.R. §§ 349.4, 360.2.
10. 18 N.Y.C.R.R. § 351.2(g).
11. 18 N.Y.C.R.R. § 360-3.2(8)(5).
12. Social Security Act §§ 1901 *et seq.*, 43 U.S.C.A. § 1396.
13. Soc. Serv. L. § 366 (1)(2)(3).
14. *Id.*
15. 18 N.Y.C.R.R. § 360-4.1.
16. 18 N.Y.C.R.R. § 360-4.9(a)(1).
17. 18 N.Y.C.R.R. § 360-4.9.
18. Soc. Serv. L. § 366-c.
19. 96 ADM-8, N.Y.S. Dep't of Social Services.

20. 18 N.Y.C.R.R. § 360-4.7(a).
21. *Id.*
22. Soc. Serv. L. § 366(2)(a) and 18 N.Y.C.R.R. §§ 360-1.4(f), 4.7(a)(1).
23. 18 N.Y.C.R.R. § 360-1.4(f).
24. 18 N.Y.C.R.R. § 360-4.3(d).
25. 18 N.Y.C.R.R. § 360-4.10.
26. 18 N.Y.C.R.R. § 360-7.11(a)(3).
27. 42 U.S.C.A. § 1396p(b)(1).
28. 18 N.Y.C.R.R. § 360-4.4(c).
29. 18 N.Y.C.R.R. § 3604.4(c)(1)(iii)(a)(2).
30. 96 ADM-11, N.Y.S. Dep't of Social Services.
31. P.L. 103-66, 1993 HR 2264.
32. 18 N.Y.C.R.R. §360-4.4(c)(2)(i)(c).
33. 18 N.Y.C.R.R. § 360-4.4(c)(2)(i)(c).
34. 18 N.Y.C.R.R. § 360-4.7.
35. Soc. Serv. L. § 366(5)(d)(3)(ii).
36. Soc. Serv. L. § 366(3)(c), 18 N.Y.C.R.R. § 360-4.3(F)(1)(i).

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This article is a revised and updated version of an article previously published in the *Trusts and Estates Law Section Newsletter,* Winter 2000, Vol. 33, No. 4, published by the New York State Bar Association, One Elk Street, Albany, New York 12207.

Tropea's Legacy: Reexamining the Impact on Relocation Analysis

By Gerda Abramson and Steven D. Cohn

Perhaps you have found yourself in the following scenario, which is not necessarily commonplace, but not unheard of, either: You receive a phone call from your client, the mother of a 12-year-old boy who was awarded visitation after a relatively uneventful divorce proceeding. Your client explains that the child's father had been assigned to Florida in the past two months for work. As their son was excited to see Florida and the move had not conflicted with his schooling, your client agreed to allow him to move for a brief time, as an extended vacation. Taking the distance into account, the father has been cooperative about working out a flexible visitation schedule. Namely, the father has paid for your client's airfare expenses to and from New York, where she continues to live and work. Recently, your client has learned that the father was offered a permanent position in Florida, which he plans to accept.

At present, the mother is maintaining roughly the same amount of visitation time as before the relocation, but she is concerned about her son. The child, a charming, articulate boy, is very fond of both parents and is dealing with the aftereffects of the divorce remarkably well. The only concern, as your client makes clear, is that the child would like to return home to New York. She refers to an e-mail her son sent her, in which he states that he misses his friends and his soccer team. Her son states that despite getting along with his father and enjoying everything that Florida has to offer, he still sees New York as home and your client worries about the effect his homesickness will have on his academic achievement once the semester begins. Her son was taking advanced classes and participating in extracurricular activities at his school in New York and had intended to continue them. While noting that her former husband has always been a concerned and involved father to their son, your client expects the father to seek permission from the court to make this move a permanent stay notwithstanding their son's apprehensions. She would like to oppose the permanent relocation. The case law in support of your position, and the steps of analysis when approaching this type of relocation scenario follow.

The New York State Court of Appeals spoke on the issue of relocation in the decision of *Tropea v. Tropea*, 87 N.Y.2d 717, 665 N.E.2d 145 (1996). The Court's holding dramatically changed the relocation law in the state of New York.

Previously, New York had one of the most restrictive relocation laws in the country. The Second Department test required a three-part analysis, with the court making the following inquiries:

1. Does the proposed move effectively deprive the non-custodial parent frequent and regular access to the children?
2. Can the custodial parent establish the exceptional circumstances necessary to justify the move?
3. If these answers were found to be in the affirmative, only then would the issue of "the best interests" of the proposed move on the child be reached.
4. *See Weiss v. Weiss*, 418 N.E.2d 377 (N.Y. 1981); *See also Daghir v. Daghir*, 439 N.E.2d 324 (N.Y. 1982).

Tropea effectively established a broad "best interests" test. Essentially, the decision left the trial courts free to hear each individual case, and to determine the issue of relocation based upon the specific facts and circumstances therein, based on a preponderance of the evidence standard. The Court indicated a variety of factors that should be considered when making these types of determinations:

1. Each parent's reasons for seeking or opposing the move, including the degree to which the custodial parent's and child's life may be enhanced economically, emotionally and educationally by the move
2. The good faith of the parents in requesting or opposing the move
3. Health-related concerns
4. The demands of a second marriage
5. The quality of the relationship between parents and child
6. The impact of the move on the quality and quantity of the child's future contact with the non-custodial parent
7. The possibility of preserving the relationship between the non-custodial parent and the child through an enhanced visitation schedule,
8. The quality of lifestyle of the child,
9. The continued or exacerbated hostility between parents if relocation were permitted and if relocation were denied
10. The effect of the move on extended family relationships

11. Or any other factor that may have a bearing on the issue.

Effectively, this new standard allowed courts a great deal of discretion in deciding a relocation case and did not require any one factor to be dispositive. This standard, while recognizing parental rights, views a child's rights and needs as paramount. *See Browner v. Kenward*, 623 N.Y.S.2d at 325, 623 N.Y.S.2d 325 (App. Div. 1995), *aff'd sub nom. Tropea v. Tropea*, 665 N.E.2d 145 (N.Y. 1996). The *Tropea* Court decided to move away from the previous rule because, in addition to application problems, the rigid three-part test prevented trial courts from considering all relevant factors in what often turn out to be exceedingly unique cases. *See Tropea*, 665 N.E.2d at 149–50. The Court also stressed that these factors were mere suggestions and a court was free to consider the totality of relevant factors in a given case.

Initially, critics of the decision feared that *Tropea* removed the necessary guidelines from trial courts, leaving the increased likelihood of inconsistent verdicts, possible omission of important factors due to the lack of a set template to measure against, and a surge in relocation grants which would, ironically, have an adverse effect on the interests of the children involved. Subsequent case law has shown that the *Tropea* guidelines have provided precisely the amount of guidance required while retaining sufficient flexibility to allow evaluation of each case in lieu of its specific facts. While some cases have continued to address "common" relocation scenarios, where one parent proposes to relocate to an area within a few hours' drive of the other parent, other cases have dealt with relocations to far more remote areas. In the former scenario, the *Tropea* guidelines can function as a quasi-checklist for the court, while more challenging later cases have required courts to deal with the issues more specifically and craft increasingly creative solutions.

Lazarevic v. Fogelquist, 175 Misc. 2d 343, 668 N.Y.S.2d 320 (1997), illustrates the modification of the *Tropea* framework to adjust to a complicated case and points out the flexibility of the *Tropea* factors. This case involving the proposed relocation of a six-year-old boy with his mother and two half-siblings to join his stepfather whose financially rewarding employment stationed him in Saudi Arabia. The factors here, which seem to focus more on parenting and the child's developmental needs, but all the while maintaining a strong focus on the child's best interest, are as follows:

1. The quality of the alternate home environments
2. A comparison of the parental guidance which would be provided to the child if relocation were granted and if relocation were denied
3. The financial status and ability of each parent to provide for the child
4. The ability of each parent to provide for the child's emotional and intellectual development
5. The desires of the child, with appropriate weight given to the child's young age and maturity
6. The quantitative and qualitative impact upon the child of losing existing contacts with one parent and the community or with the other parent and a new stepparent and siblings, where applicable
7. The quantitative and qualitative impact upon the non-custodial parent of losing existing contacts with the child
8. The feasibility of devising a visitation schedule or other arrangement that will enable the non-custodial parent to maintain a meaningful parent-child relationship
9. The difficulty, advantage and disadvantage that the child will experience in residing and adapting to a remarkably new and different place and culture
10. The economic necessity or lack thereof for wanting to relocate
11. The existence of good faith in requesting and opposing the relocation and whether Respondent's reasons for moving are valid and sound
12. Respondent's attempts to obtain a "fresh start," i.e., whether relocation would strengthen and stabilize the new post-divorce family unit, and
13. The continued or exacerbated hostility between parents if relocation were permitted and if relocation were denied.
14. *Lazarevic v. Fogelquist*, 175 Misc. 2d 343, 668 N.Y.S.2d 320 (1997), citing *Eschbach v Eschbach*, 56 N.Y.2d 167, 451 N.Y.S.2d 658, 436 N.E.2d 1260 (1982).

Interestingly enough, one of the initial *Tropea* criticisms—namely, that more relocation petitions will be granted—may have come true, albeit with a caveat. The pre-*Tropea* rule disfavored relocation when the non-custodial parent would have limited access to the child. More recently, the type of access that one thinks of when discussing visitation has begun an interesting transformation.

Courts in several states, including neighboring New Jersey and Connecticut, have considered Internet, telephone and other 'virtual' visitation as suitable alternatives or supplements to in-person visitation in certain cases. These options ensure that the parent-child relationship is fostered through instantaneous communication when travel between parental households proves too expensive, time-consuming or physically demanding for children or their parents. New York is not far behind this trend. In *Lazarevic v. Fogelquist*, 175 Misc. 2d

343, 668 N.Y.S.2d 320 (1997), a mother was instructed to install and provide Internet, fax and a separate phone line for a telephone and answering machine for her son to more easily communicate with his father, when the child and mother relocated to another country. Moreover, these devices were to be installed at the relocating mother's expense and made available in the child's bedroom.

Such findings are hardly surprising when viewed in light of psychological studies, like those of psychologist Judith S. Wallerstein, who filed an *amicus curiae* brief to the California Supreme Court in the landmark *Burgess v. Burgess*, 51 Cal. Rptr. 2d 444 (1996), which indicated that contact between the non-custodial parent and child was only required to be qualitatively, not quantitatively rich to serve the best interests of the child. Thus, although relocation may take away the ability for a non-custodial parent to visit one's child for a quick hug or to attend a school play, the effect on the child will not be disastrous. Phone calls, faxes and e-mails enable the paths of communication to remain open when, on the whole, a move provides the child with an overall increase in quality of living.

In sum, the outcome of relocation cases may be more difficult to assess at the outset and there is no easy answer to provide our hypothetical client regarding her son's possible permanent relocation to Florida. However, the guidance provided in *Tropea* has enabled courts to weigh all relevant factors of a proposed relocation on a case-by-case basis. Maintaining a clear view of the facts and critically balancing the pros and cons of the relocation on the child's interests, although never clearly black and white, tip the scales in favor of or against allowing the move.

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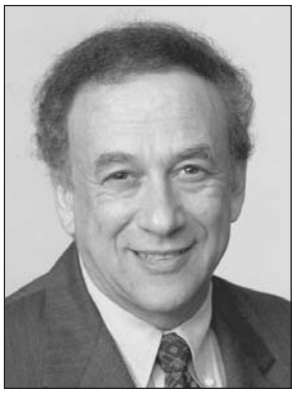
Parental Responsibilities and Rights

By Martin Minkowitz



If you die as a result of an injury you sustain in the course of your employment and that injury arose out of that employment (while you may not personally be entitled to anything anymore), there are death benefits that are payable under the Workers' Compensation Law.[1] These can be substantial and have often meant the difference between the surviving spouse and children depending on public assistance or not. They will become the claimants at the Workers' Compensation Board.

First, there is the benefit for funeral expenses, which is paid subject to the limitations of fee schedules, which are part of the rules promulgated by the Chairman of the Workers' Compensation Board. These are paid by your employer or its insurance carrier, even if there is no surviving spouse or children. If a claimant pays the funeral expenses, reimbursement is made to that claimant. However, if the payments were not made by a claimant, the undertaker has the right to be paid for the burial.

Then there is the benefit paid to a surviving spouse or child under the age of 18 (unless blind or physically disabled) or under 23 years of age if a full-time student. It is two-thirds of the deceased's average weekly wage at the time of the accident causing the death. The spouse gets $36^{2}/_{3}$ of the average weekly wage of the deceased. If the spouse remarries, it converts to two years' lump-sum payout. The child or children get the other 30% of the $66^{2}/_{3}$ to share and share alike. If that seems simple so far, then read on because now it gets complicated.

If at the time of your death you did not have a spouse or any qualifying children, the benefits could be payable to your grandchildren or brothers or sisters, if they were dependent on you, or could qualify under the same conditions established for your child, (i.e., under the age of 18, etc.). However, if none of those exist, then $50,000 is payable to your surviving parents. (If there are no surviving parents, the $50,000 would go to your estate.)[2]

What happens in the situation where a father voluntarily moves out of the marital home and leaves the state, contacting his son only two times in his life before the son died in a work-related accident. One of those was at a funeral and his father did not even speak to him. The father never provided financial support even after a court order to do so was obtained. The mother raised the deceased and another son without the assistance or presence of the father. Both children graduated college and became successful. Upon the death of her son, the mother filed for the $50,000 and the father intervened, claiming half of the money.

The Board concluded that since there is no condition placed on the term "parent" in the Workers' Compensation Law, the father was entitled to one-half of the $50,000 awarded. The majority of the Appellate Division affirmed, finding that the term *parent* as used in the statute is clear and unambiguous and should be given to commonly understood meaning. It noted that since the father's parental rights were never legally terminated under the Social Service Law, it should not disturb the Board's decision to give the father half the benefits awarded. It did point out that the dissent noted that "parents who fail to provide for or who abandon their child are expressly disqualified by statute from inheriting from a child who dies intestate and from receiving the proceeds of an action for the wrongful death of the child." However, there is no comparable exclusion in the Workers' Compensation Law. The court then said that it viewed this omission as an indication that the legislature never intended such an exclusion.[3]

This case is a wake-up call to the Workers' Compensation Board and the legislature. As the dissent eloquently put it, the right of a parent to the services or earnings of a child should be linked to the actual support of the child and not just a biological link. To consider a parent to be one who has not brought up or cared for their child is to give a construction to the term *parent* that is an absurdity and causes mischief. A parent who expects to be entitled to parental rights must be more than a mere biological father or mother. He or she must be one who is willing to assume parental responsibilities for bringing up, caring for and supporting the child. The legislature has introduced bills to correct this situation and hopefully will act expeditiously.

Endnotes

1. WCL § 16.
2. WCL § 16(4-b).
3. *Caldwell v. Alliance Consulting Group*, __ A.D.2d __ (2004).

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State Insurance Guaranty Funds: A Precarious Safety Net for Commercial Insurance Consumers

By Martin Minkowitz

Overview

Guaranty funds have always emphasized the needs of noncommercial insurance consumers (i.e., those purchasing private passenger auto or homeowners insurance coverage) over those of commercial policyholders. For example, most states limit an individual's maximum guaranty fund recovery to $300,000 per claim (for claims other than workers' compensation claims)—well below the policy limits typically associated with liability insurance policy coverage for large corporations. Similarly, the majority of states exclude from coverage policyholders whose net worth exceeds specified amounts that generally range from $5 million to $50 million.

"This article looks at the limitations for commercial insureds of the state guarantee fund system and, in light of these issues, some of the steps commercial insureds should consider when choosing an insurance carrier."

Notwithstanding these limitations, commercial insureds have believed that guaranty fund coverage would afford them at least partial relief if their carrier became insolvent. However, recent reports of the financial difficulties of the state guaranty funds in California and New York, to name only two, suggest that assumption may not be valid, and that commercial insureds should select their insurance carrier with the recognition that state guaranty funds may be unable to pay their insurance claims if the insurance carrier becomes insolvent.

This article looks at the limitations for commercial insureds of the state guarantee fund system and, in light of these issues, some of the steps commercial insureds should consider when choosing an insurance carrier.

Guaranty Fund Limitations and Exclusions

The majority of state guaranty fund acts are identical to, or closely resemble, the National Association of Insurance Commissioners ("NAIC") Post-Assessment Property and Liability Insurance Guaranty Association Model Act (the "NAIC Model"). Under the NAIC Model, after a property/casualty insurer has become insolvent, solvent property/casualty insurers are assessed their proportionate share of "covered claims" of the policyholders of the insolvent insurer.

As noted above, one problem for commercial insureds in many states is that state guarantee fund coverage limits and exclusions may limit them to only a very small recovery, or none at all. For example, under the NAIC Model, "covered claim" does not include amounts awarded as punitive or exemplary damages. The NAIC Model expressly excludes first-party claims by any insured with a net worth in excess of $25 million. Net worth under the NAIC Model includes not only an insured's stand-alone net worth, but also that of its subsidiaries on a consolidated basis. Most states exclude from coverage policyholders whose net worth exceeds specified threshold amounts that generally range from $5 million to $50 million. Thus, even if the losses of a large commercial policyholder are within the guaranty fund coverage limits, they will recover nothing if their net worth exceeds the threshold.

In addition to limits on the first-party claims of high-net-worth policyholders, the NAIC Model also limits coverage with respect to third-party claims. Policyholders with a net worth of $50 million or greater are required to repay the guaranty funds any amounts paid to third-party claimants on their behalf. As a result, many larger corporations and groups inevitably will be excluded from guaranty fund coverage—particularly troubling for large commercial policyholders because many recent insurer insolvencies have involved commercial lines carriers.

Most states limit an individual's maximum guaranty fund recovery to $300,000 per claim (for claims other than workers' compensation claims), with some states limiting claims to as little as $100,000. These state-to-state differences have been criticized, as a person or entity located in a state with a $500,000 cap may recover as much as $400,000 more than claimants in states with less generous limits.

Strained Guaranty Funds

Even if state guaranty funds provided broader coverage to large commercial policyholders, the troubled financial condition of funds in several large states is sobering evidence that they might be unable to fulfill

their obligations to policyholders. In California, the State Compensation Insurance Fund, California's workers' compensation pool, reportedly suffered a net loss of $66.1 million in 2002. The California Insurance Guaranty Association ("CIGA") would assume the Fund's obligations, with certain exceptions, if the Fund were unable to meet them. However, CIGA reportedly has financial difficulty of its own, and the added burden of satisfying the Fund's obligations could compromise CIGA's ability to pay its own claims.

In New York, the Public Motor Vehicle Liability Security Fund (the "PMV Fund") is unable to meet its defense/indemnification obligations to defendants in various personal injury actions. The only remedy appears to be legislative action to increase the insurance assessment, as a New York state court recently ruled in *Montemarano v. Serio* that the Superintendent does not have statutory authority to impose such an increase.

Conclusion

Commercial insureds face two levels of bad news regarding their liability insurance coverage. For many, because of the statutory coverage limitations and exclusions discussed in this article, if their insurance carrier becomes insolvent, they may be entitled to recover from the state guarantee fund only a small portion of their claims, or even none at all. Even if they are entitled by statute to reimbursement by the guarantee fund of a significant portion of their losses, the financial strains on state guarantee funds may mean that as a practical matter, the guaranty funds will be unable to pay all, or any portion, of the amount to which they are entitled.

The lesson for insurance consumers is that guaranty funds are not unbreakable safety nets that will make them whole. They must engage in careful due diligence regarding their insurance carriers, conducting thorough research into the stability of their insurance carriers. Many commercial insureds may find it both more efficient and safer to return to the basics when selecting a carrier: financial strength, history and credit rating. Given the limitations of the state guarantee fund system, many commercial insureds and licensed insurance producers are likely to look to well-established insurers with substantial surplus and capital and solid credit ratings. This change in attitude will become increasingly evident among producers who wish to avoid any potential future liability in connection with a carrier's insolvency.

"Many commercial insureds may find it both more efficient and safer to return to the basics when selecting a carrier: financial strength, history and credit rating."

Martin Minkowitz is a partner in the Insurance & Reinsurance Practice Group at Stroock & Stroock & Lavan LLP. He wishes to acknowledge Todd Zornik, an associate in Stroock's Insurance & Reinsurance Practice Group, for his assistance in the preparation of this article. Portions of this article were previously prepared on behalf of a client and were reproduced with that client's permission. This article was written strictly for informational purposes and does not constitute legal advice.

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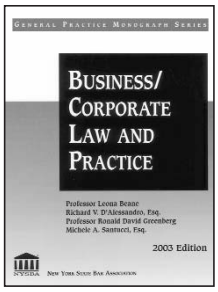

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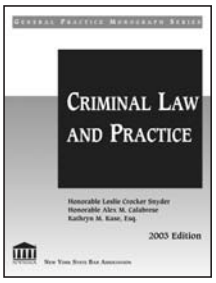

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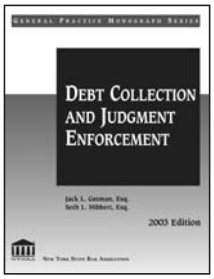

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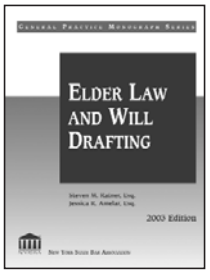

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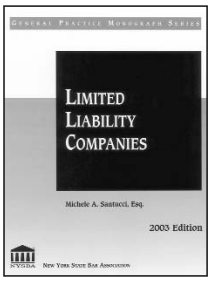

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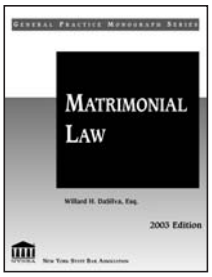

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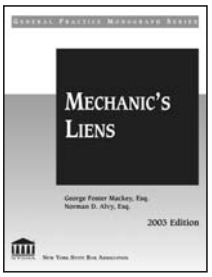

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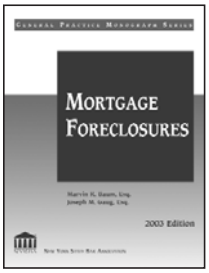

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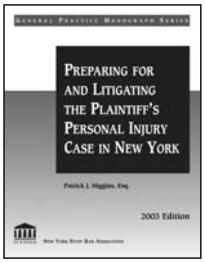

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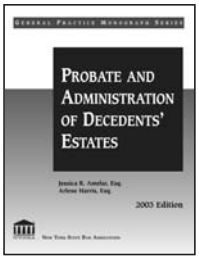

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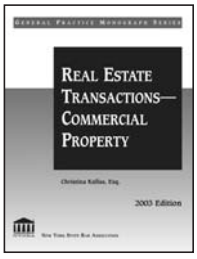

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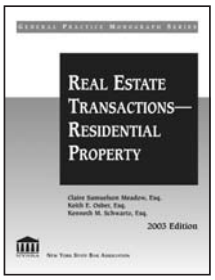

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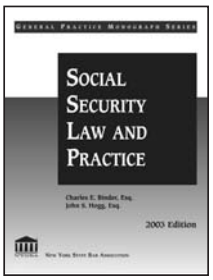

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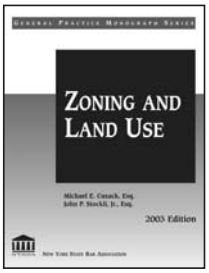

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ISSN 0733-639X

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