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A few short years ago, NAELA broadened its elder-focused mission statement to “enhance the lives of people with special needs and people as they age.” Recognizing that our legal practices not only affect our senior clients but also a younger disabled population, we embraced this reality. Our thirst for more education in this area has grown exponentially. This prestigious Journal reflects our journey into the special needs arena with two excellent articles: one discussing Supplemental Security Income (SSI) planning and another discussing Special Needs Trusts (SNTs).

While this Journal expresses the expansion of our practices into new areas, it also honors our fundamental interest in the laws affecting the elderly. What is particularly exciting about this Journal is its timely and cutting-edge topics. The articles lead us into the future rather than dwell on the past, and that is what NAELA is all about.

LEADERSHIP. The topics picked by our editors for this publication make the leadership statement for us. Changing paradigms in Lawyering for Older Clients contains many new ideas. Discussing Medicare Part D is certainly a key topic as the new federal prescription drug program is launched simultaneously with this publication. From important instruction about Medicaid and long term care solutions to significant guardianship questions that every elder law attorney should consider, this Journal exhibits articles of profound value.

The leadership point is also brought out with the article about elder clients with diminished capacity. This is the first national article to apply NAELA’s new Aspirational Standards for the Practice of Elder Law. Created by NAELA, these Aspirational Standards raise the bar for representation of the elderly. You should also know that NAELA membership voted to support these standards as a condition of their Academy membership. As such, NAELA members have pledged to operate at a higher standard. This is real leadership and this article honors that commitment.

I am proud to be the President of NAELA and I am proud of the leadership that this Journal represents. Enjoy!
THE MEDICARE DRUG BENEFIT: A PRESCRIPTION FOR CONFUSION

Richard L. Kaplan, Esq.*

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I. INTRODUCTION

Near the end of 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act (hereinafter referred to as “the Act”),¹ which represented the largest expansion of Medicare’s scope since that program was created in 1965.² Though the Act has many features affecting Medicare beneficiaries and the health care providers who care for them, its most salient part is the creation of a broadly available program to cover the cost of outpatient prescription medications.³ That part takes effect in 2006,⁴ more than two years after it was enacted. This delayed effective date recognizes the wide-ranging significance of this program, which is denominated Medicare Part D and is the focus of this article.

The article begins by setting forth some basic background to better understand the constraints under which Congress was legislating. It then considers the convoluted structure of the Medicare Part D benefit itself. The article then analyzes the options that Medicare enrollees and their advisors face in terms of Medicare Part D versus other arrangements for financing their prescription drug costs. The article concludes with some observations about the dilemmas that Medicare Part D presents for clients of elder law attorneys.

II. BACKGROUND TO THE 2003 ENACTMENT

A. Role of Drugs in Medical Care

In the nearly four decades since Medicare was enacted, the role of prescription drugs in medicine has changed radically.⁵ Medications have been developed to control the debilitating effects of a wide range of maladies, especially chronic medical conditions such as diabetes, hypertension, asthma, and heart disease.⁶ Existing drug regimens, moreover, have been refined to more precisely target appropriate pharmaceutical interventions to patients with ever more individualized medical profiles. As a result, drug efficacy has increased while side effects have been minimized. The prospects for even greater pharmacological progress seem brighter than ever. The bottom line is that prescription drugs have become a major component of medical care for all Americans, but especially for those Americans who are aged 65 years and older. Consequently, many Medicare beneficiaries now take several different

⁶. See Earl P. Steinberg et al., Beyond Survey Data: A Claims-Based Analysis of Drug Use and Spending by the Elderly, Health Aff. (Mar.-Apr. 2000), at 198, 199.
pills as part of their regular routine, rather than for specific episodes of some medical incident.

Related to this development is the significant increase in the cost of drug regimens.\(^7\) Drugs tailored for specific populations are usually more expensive than drugs for common conditions, and as the range of available medications has grown, their cost has become a major expense for clients who need to take these medications on a more-or-less permanent basis. According to recent estimates, prescription drugs constitute the second largest component of seniors’ out-of-pocket medical expenses.\(^8\)

B. Medicare’s Noncoverage of Drugs

Yet Medicare, the health care system for older and disabled Americans, does not cover the cost of prescription drugs outside the hospital context. That was the situation in 1965, and Medicare’s coverage had not responded to the greatly increased prominence of drug therapy in modern medicine. Indeed, Medicare in 2003 was one of the few general health care plans available to Americans that did not provide some coverage of outpatient medications, and certainly the most prominent.

In many cases, this situation leads to medically bad and economically perverse results. Because Medicare does not cover the cost of needed medications, some Medicare patients forego taking these pills to avoid the associated expense. If the underlying medical condition subsequently gets out of control, the patient often requires hospitalization to stabilize his or her situation. The cost of such hospitalization exceeds the cost of the drugs that were not taken by many degrees of magnitude, but Medicare covers the costs of hospital care, largely in full.\(^9\) Thus, Medicare’s lack of drug coverage often ends up costing the program many times more than the cost of maintenance drugs that could have prevented these hospitalizations.\(^10\)

Indeed, it is precisely for this reason that some companies offer their employees prescription drugs at little or no financial cost: the expense of these drug regimens is dwarfed by the cost savings from prevented hospitalizations.\(^11\) Medicare’s lack of drug coverage, in other words, is both medically outdated as well as economically counterproductive.

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10. See Robert Pear, Clinton Will Seek a Medicare Change on Drug Coverage, N.Y. Times A1 (June 8, 1999) (reporting that every $1 spent on prescription drugs saves $3.65 on hospital costs).
C. Prior Attempt to Add Drug Coverage to Medicare

To be sure, Congress tried to address this problem previously in the Medicare Catastrophic Coverage Act of 1988 (MCCA),\textsuperscript{12} which authorized Medicare to cover the cost of prescription drugs.\textsuperscript{13} MCCA financed the cost of this new coverage through a monthly premium of $4 and fifteen-percent surtax on the federal tax liability of Medicare enrollees with tax liabilities in excess of $150.\textsuperscript{14} This surtax was limited to a maximum of $800 per person (or $1,600 per married couple),\textsuperscript{15} and only the wealthiest 5 percent of Medicare beneficiaries were expected to pay the maximum amount.\textsuperscript{16} Indeed, only about 36 percent of Medicare enrollees were projected to owe any surtax at all.\textsuperscript{17} Nevertheless, the outcry from those senior citizens who anticipated that they would pay this additional charge was so vociferous that Congress repealed MCAA’s financing provisions and the associated drug benefit the very next year.\textsuperscript{18} The widely televised scene of angry senior citizens (who were dubbed the “Gray Panthers”) literally assaulting the Chairman of the House Ways and Means Committee and preventing him from getting into his car\textsuperscript{19} seared the collective memory of the Congress and affected how they approached the issue of adding prescription drugs to Medicare in 2003.

D. Political Development of the Medicare Drug Issue

The repeal of MCAA, however, did not eliminate the problem of paying for increasingly expensive prescription drugs. Less than a decade later, older Americans made adding a prescription drug benefit to Medicare a hot political issue. Candidates competed for the votes of this politically engaged and well-organized constituency by offering various plans, with different levels of co-payments, deductibles, annual limitations, and other key programmatic parameters.\textsuperscript{20} This issue was a major focus in the election of 2000,\textsuperscript{21} though nothing actually passed the Congress. The issue gained

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\textsuperscript{15} Id.

\textsuperscript{16} Id.

\textsuperscript{17} Id.

\textsuperscript{18} Id. at 96.

\textsuperscript{19} Id. at 29-31.


\textsuperscript{21} See, e.g., Laurie McGinley & Shailagh Murray, Lawmakers Sweeten Drug-Benefit Plans to Gain Edge With Voters, Wall St. J. A48 (June 26, 2000); David Brown, For Medicare, An Inadequate Prescription, Wash. Post A1 (June 26, 2000); Jackie Calmes & Laurie McGinley, Bush Unveils
renewed prominence in the mid-term elections of 2002, and President George W. Bush did not want to go into the 2004 election with no resolution of this issue, especially since his own Republican Party had controlled both the House of Representatives and the Senate throughout his presidential term. The product of these political imperatives was a concerted effort throughout 2003 to provide a drug benefit in Medicare that would update that program's coverage without engendering the sort of uncontrollable anger that doomed MCCA fourteen years earlier. The need to address this issue was bolstered by a survey that was conducted by AARP in 2002. That survey asked respondents who were at least 45 years old the following question “How would you feel if the Senate fails to pass a prescription-drug bill this year?” Fully 61 percent replied “angry.”

Congress passed the Act in 2003 after much internal wrangling, and President Bush signed it on December 8 of that year. It provided some interim relief in the form of drug discount cards that became available in mid-2004, but the real drug benefit, Medicare Part D, starts in 2006.

III. THE ACT’S DRUG COVERAGE

A. Design Objectives

In fashioning a drug benefit for Medicare, Congress had several objectives that affected the design of the program that was ultimately adopted. First, it had to be


23. See Iglehart, supra n. 2, at 826.


26. Id.


voluntary. The overriding lesson that was taken from the enactment of MCCA and its subsequent repeal was that many seniors do not want to pay for a benefit that they personally do not need. For that reason, only those persons who choose to be part of the new program are assessed monthly premiums to pay for it. Those who do not want its benefits have the option of nonenrollment and avoidance of additional costs.

Second, and a direct correlate of this voluntariness principle, the program must provide real benefits at a fairly modest level of annual drug expenditures. That is, like most medical phenomena, the distribution of drug expenses is highly concentrated, with most patients having minimal financial exposure and a relatively few patients having very significant expense. But to better spread the risks of insuring this population, the program must appeal to a broad range of Medicare enrollees and not just to those with the highest anticipated drug costs.

Third, government funds are always limited, so the program must choose its targets carefully. Indeed, some lawmakers opposed creating any drug benefit in Medicare because such an addition necessarily increases that program’s long-term financial solvency problems. Thus, some programmatic limits were politically required, but there was considerable agreement that Medicare should provide significant benefits to those with minimal financial resources and to those whose drug needs are particularly expensive.

B. The Act’s Coverage Components

To accommodate the plan design objectives just described, Medicare Part D was fashioned like no other pharmaceutical coverage in the world. It has several distinct components:

- Premiums of approximately $35 per month, according to the best available current estimates.
- Annual deductible of $250, for which the enrollee pays all of the cost.
- A 25 percent coinsurance for the next $2,000 of annual pharmaceutical expenditures; i.e., for annual drug costs of $2,250.
- A 100 percent coinsurance – that is, no benefits whatsoever – for the next $2,850 of annual pharmaceutical expenses; i.e., annual costs of $5,100, colloquially referred to as the “doughnut hole.”
- A 5 percent coinsurance for all remaining pharmaceutical expenses; i.e., annual drug costs in excess of $5,100.

This bizarre scheme can be represented graphically as follows:

From this brief description, several key features are evident. First, monthly premiums of $35 (approximately) translate into an annual cost of $420, which when combined with the plan’s annual deductible of $250, means that persons who anticipate drug costs of less than $670 per year may choose not to enroll in Medicare Part D. Accordingly, there is significant potential for “adverse selection” whereby only those persons who expect to pay more than $670 per year for prescription drugs will enroll in this plan. And, a plan that contains only persons who expect to receive benefits in excess of their contributions cannot fulfill the “risk spreading” function that is the essence of insurance.

Second, all of the plan’s parameters depend upon cumulative expenditures. Part D enrollees must therefore maintain ongoing records of total drug costs or utilize a single pharmaceutical outlet that will keep track of these costs. Once the so-called “doughnut hole” level is reached in which Part D pays no benefits (i.e., annual costs between $2,250 and $5,100), these records become even more important, because they ensure that the final level of 5 percent coinsurance (i.e., annual costs exceeding $5,100) is accurately monitored.

threshold will be indexed after 2006. At this level, the consumer will pay $2 per prescription for generic drugs and $5 per prescription for brand name drugs, if these amounts exceed 5 percent of the drugs’ cost.


Third, this arrangement requires its enrollees to pay substantial sums before benefits are received. For example, after the $2,250 tier is reached, the enrollee must incur annual drug expenses of another $2,850 before a single penny of Medicare benefit is obtained. As a result, Medicare Part D potentially leaves significant costs in the hands of its enrollees.

In this connection, consider Lynette whose medical condition requires her to spend $500 per month, or $6,000 per year, on prescription drugs. Under Medicare Part D, her portion of these costs would be determined as follows:

- Monthly premium ($35, estimated) for twelve months: $420
- Annual deductible: $250
- Co-payment of 25 percent for costs between $250 and $2,250 (i.e., $2,000): $500
- All costs between $2,250 and $5,100: $2,850
- Co-payment of 5 percent for costs exceeding $5,100 (i.e., $6,000 - $5,100 = $900): $45
- Total costs to Lynette: $4,065

Thus, even with Medicare Part D, Lynette ends up paying more than two-thirds of her total drug expenditures.

The impact of this multi-level cost-sharing arrangement is illustrated by the following chart:

<table>
<thead>
<tr>
<th>Annual Drug Costs</th>
<th>Enrollee Pays*</th>
<th>Net Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>$500</td>
<td>$732.50</td>
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<tr>
<td>$1,000</td>
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<td>$142.50</td>
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</tr>
<tr>
<td>$10,000</td>
<td>$4,265.00</td>
<td>$5,735.00</td>
</tr>
</tbody>
</table>

* Includes $250 annual deductible and estimated $35 monthly premiums.

Notice that even at a fairly catastrophic level of $10,000 per year of annual drug costs, the enrollee pays nearly 43 percent of the total bill.

Recognizing that this scheme would be particularly harsh on lower-income enrollees, Congress provided more generous benefits to persons with limited income. Beneficiaries with limited savings and incomes below 135 percent of the federal poverty line receive the following: (1) no deductible, (2) no monthly premiums, (3) no gap in coverage, (4) co-payments of $2 for generic drugs and $5 for all other drugs, up to an out-of-pocket limit of $3,600, and (5) no co-payment for prescriptions once the out-of-pocket limit is reached. In 2006, 135 percent of poverty is projected to require annual incomes below $13,000 for a single individual and $17,000 for married couples.37

Beneficiaries with limited savings and incomes below 150 percent of the federal poverty line receive the following: (1) a sliding scale monthly premium that would be about $35 for beneficiaries with incomes of 150 percent of the federal poverty level, (2) an annual deductible of $50, (3) no gap in coverage, (4) coinsurance of 15 percent up to an out-of-pocket limit of $3,600, and (5) co-payment of $2 or $5 once the out-of-pocket limit is reached. In 2006, 150 percent of poverty is projected to require annual incomes below $14,000 for a single individual and about $19,000 for a married couple.40

For persons whose income exceeds 150 percent of federal poverty levels, Medicare Part D’s benefit structure applies as explained above.

C. Delayed Enrollment Penalty

To counter the adverse selection phenomenon that a voluntary program like Medicare Part D necessarily has, the Act provides that delaying enrollment has a financial cost. A late enrollee will be accepted regardless of his or her medical condition—unlike the medical underwriting that private insurance plans employ. But the premium that will be charged will be increased as long as that enrollee remains in Medicare Part D. Thus, a decision to defer enrollment in Part D has financial consequences if an eligible person eventually chooses to enroll in this program.

Subject to certain actuarial limits, the penalty is 1 percent for every month during which a beneficiary did not have “creditable” prescription drug coverage. For example, assume that Paul decides not to obtain any drug coverage in the first five years during which he was eligible to enroll in Medicare Part D. Five years is sixty months, so Paul will face a 60 percent penalty if he subsequently enrolls in Part D. If the monthly premium by then is, say $45, Paul will pay 60 percent (i.e., $27) more, resulting in a monthly premium of $72 instead of $45. And as the monthly Part D premium increases over time, the 60 percent penalty will be applied to whatever the

current charge becomes. This 60 percent surcharge continues, it should be emphasized, as long as Paul remains in Medicare Part D. It never ceases.

This penalty does not apply, however, if a Medicare beneficiary has “creditable” coverage prior to that person’s enrolling in Medicare Part D. “Creditable” coverage is drug coverage that meets or exceeds the actuarial value of the Medicare Part D prescription drug coverage. “Creditable” coverage can be:

- A prescription drug plan or managed care plan with drug benefits;
- Medicaid;
- A group health plan (including the Federal Employees Health Benefit plan and a “qualified retiree prescription drug plan”);
- A state pharmaceutical assistance program;
- Veterans’ coverage of prescription drugs;
- Prescription drug coverage under a medigap plan;
- Military coverage; and
- Any other coverage that the government determines is appropriate.

Clearly, many alternatives are available, but if an enrollee “goes bare,” as Paul did in the preceding example, the deferred enrollment penalty will apply if the enrollee subsequently enrolls in Medicare Part D.

IV. CLIENT-CENTERED DECISION-MAKING

The prescription drug benefit in Medicare Part D will appeal to many clients, but for other clients, the decision will be more complicated. The source of this complication is that three out of four Medicare beneficiaries already had some sort of drug coverage before Medicare Part D was enacted. According to the Centers for Medicare and Medicaid Services, the administrative agency that operates Medicare, approximately 12 percent had drug coverage through Medicaid based on their dual eligibility, and another 5 percent had such coverage through the Veterans’ Administration, Department of Defense, or certain income-based state programs outside of Medicaid. For these persons, the new drug benefit in Medicare probably changes relatively little.

But fully 33 percent of Medicare beneficiaries had some degree of drug coverage through employer-sponsored plans, 15 percent had such coverage through private medigap insurance, and another 11 percent were enrolled in Medicare managed care plans. In other words, of those Medicare beneficiaries who have drug coverage presently, nearly four out of five face the dilemma of staying with their present arrangement or electing Medicare Part D in its place. This section focuses on their situations.

47. See id.
48. See id.
49. Employer-sponsored plans (33%) + medigap (15%) + managed care (11%) = 59%, which as a
A. Employer-Sponsored Coverage

Employer-sponsored health insurance for retirees usually includes some degree of drug coverage. But such plans come in a wide array of variations, with differing levels of monthly premiums, co-payment levels for individual prescriptions, and lists of included pharmaceuticals. Many of these plans simply continue benefits that the retiree received while he or she worked at the plans’ sponsoring employer.

1. Patterns of Declining Coverage

Many people with such coverage, however, are concerned that they might lose their benefits or that the existing coverage will be curtailed in the future. Such concerns have a substantial basis in fact. Health benefits generally are an increasingly expensive component of employee compensation packages, and drug benefits in particular are often targeted for cutbacks of one sort or another. After all, employers have no legal obligation, barring union contracts or other binding arrangements, to provide any drug coverage. And when changes in existing plans are contemplated, which group of beneficiaries is an employer more likely to select to bear a larger share of these costs—current employees or retirees? As a result, employers regularly make changes in retiree health benefit plans, whether by increasing the monthly charge paid by retirees, increasing the co-payment amount or percent paid by retirees for covered services, or restricting the formulary to specified medications or their generic equivalents.50

Overall, the percentage of private-sector employers that offer health benefits to Medicare-eligible retirees has declined from 20 percent in 1997 to 13 percent in 2002.51 Even among very large such employers, those with 1,000 or more employees, the percentage that provides health benefits to their retirees has declined from 80 percent in 1991 to 56 percent in 2003.52 Moreover, a survey of employers about anticipated changes in existing retiree health benefit plans revealed that the most likely change was to increase the retirees’ share of the premium cost.53 Making the plans more generous was considered unlikely by nine out of ten responding employers.54 Little wonder then that even retirees with retiree health plans that include drug benefits are fearful of what changes may be forthcoming to their plans.

This fear became especially palpable on April 23, 2004 when a federal agency, the Equal Employment Opportunity Commission (EEOC), approved a rule that explicitly allows employers to reduce or eliminate company-provided health benefits
to Medicare-eligible retirees.\textsuperscript{55} This rule reversed the EEOC’s prior policy that held such changes to violate the Age Discrimination in Employment Act.\textsuperscript{56} In fact, this new rule purports to overturn a court victory by retirees who challenged an employer that offered lower benefits to Medicare-eligible retirees than to retirees who were not yet eligible for Medicare benefits.\textsuperscript{57} Whether the new EEOC policy will be upheld in court remains to be seen,\textsuperscript{58} but it is difficult to interpret this change as anything other than a green light to employers who want to lower their operating expenses by curtailing health benefits for former employees.

2. Stay or Switch to Medicare Part D

For persons who presently have employer-sponsored coverage of prescription drugs, the question of whether they should switch to Medicare Part D is particularly difficult. Without a doubt, the most problematic aspect of this dilemma is trying to divine what the employer-sponsored plan will look like in the future. Will the employer raise the monthly premium that the retiree pays? Will the co-payment level be increased? Will the plan’s drug coverage apply only to generic pharmaceuticals or those available from so-called “multiple sources”? Will an annual cap be imposed or an existing cap lowered? Will the plan be terminated in its entirety? This last concern was critical even before the EEOC’s ruling that employers may terminate plans for Medicare-eligible retirees without violating the age discrimination statute. How much more likely will employers be to terminate their plans now that Medicare Part D provides an alternative?

This issue of “crowding out,” of Medicare Part D encouraging employers to drop their existing coverage of retirees’ drug costs, was an extremely critical issue in the Act’s development.\textsuperscript{59} Indeed, this issue was one of the most contentious aspects of the Medicare drug debates and required some resolution or the Act might never have been enacted.\textsuperscript{60} How, then, does the Act resolve this conundrum?

An employer may provide drug coverage that is better than the coverage provided by Medicare Part D. Alternatively, an employer may provide coverage to its retirees that supplements the prescription drug benefits provided under Medicare Part D, a Private Drug Plan (PDP), or a managed care alternative, the Medicare Advantage-Prescription Drug (MA-PD) plan. Because many seniors currently benefit from employer-sponsored health care coverage, the Act provides a federal subsidy to employers that maintain their current coverage of prescription drugs for retirees. Once

\textsuperscript{57} Erie Co. Retirees Ass’n v. County of Erie, Pa., 220 F.3d 193 (3d Cir. 2000).
\textsuperscript{58} See AARP v. Equal Employment Opportunity Comm’n, 34 Employee Benefit Cas. (BNA) 2138, 2005 WL 723991 (E.D. Pa.) (ruling that the EEOC’s regulation is contrary to law and may not be implemented), vacated 2005 WL 2373863 (E.D. Pa.).
\textsuperscript{59} See Weissert, supra n. 24, at 4; Wessel, supra n. 27, at A1.
certain criteria are met, an employer can receive a payment equal to 28 percent of the beneficiaries’ drug costs between $250 and $5,000 per year. As a result, this federal subsidy will vary from employer to employer but might be as high as $1330 per beneficiary per year.

To qualify for this subsidy, employers must take three steps to provide coverage that constitutes a “qualified retiree prescription drug plan.” First, the employer or sponsor of the plan must prove to the government that the actuarial value of the employer’s plan is at least equal to the actuarial value of the prescription drug coverage under Medicare Part D. Second, the employer or sponsor must provide the necessary documents to the government to verify the adequacy and payment of coverage. Third, the employer must notify individuals who are eligible for Medicare Part D if the employer’s coverage does not meet the actuarial equivalence requirement, so these individuals can enroll in a prescription drug plan, a MA-PD plan, or apply for a waiver of the equivalency requirement.

The open question, of course, is how will employers react to the Act’s proffered subsidy. After all, many employers already receive substantial federal tax benefits when they deduct the cost of prescription drug benefits from their taxable income. For taxable employers, this deduction is equivalent to a subsidy from the federal government of as much as 35 percent. Now, those employers will receive an additional 28 percent subsidy from the Act’s provisions. This additional subsidy, moreover, is free of federal income tax. To be sure, some employers do not owe any federal income taxes; e.g., state and local governments, charitable organizations, and profit-seeking enterprises with substantial tax losses being carried forward to offset current income. But all employers can benefit from the 28 percent subsidy payments.

On the other hand, this subsidy relates to the cost of providing drug benefits only up to $5,000 per year. More generous prescription drug benefits yield no additional federal subsidies to the sponsoring employers. Will those employers, therefore, modify their plans to cap an individual retiree’s prescription medication expenditures at $5,000 per year? Will the 28 percent subsidy be sufficient to overcome the other tendencies to curtail or limit existing retiree health coverage of prescription drugs? No one knows, but the stakes are huge, both for employers with existing drug benefit plans and for their retirees.


62. That is, the maximum qualifying coverage is $4,750 ($5,000 minus $250), which when multiplied by 28 percent, yields $1,330.


65. Id. at § 1860D-22(a)(2)(B).


67. A tax deduction reduces an employer’s federal tax liability by the applicable tax rate, which can be as high as 35 percent. I.R.C. § 1(i)(2) (individual taxpayers), § 11(b)(1)(D) (corporations).

68. Act § 1202(a), 117 Stat. 2480, adding I.R.C. § 139A.
Some employers that do not currently provide drug coverage for their retirees might even be encouraged to start doing so. Such a development would undoubtedly benefit the retirees of these employers, since employer-sponsored drug benefit plans do not have the strange benefit structure that characterizes Medicare Part D, especially the coverage gap or “doughnut hole.” But for employer plans with annual caps, some retirees might actually fare better under Medicare Part D. After all, once an enrollee reaches the last tier of benefits, annual drug costs of $5,100, all further drug expenditures are covered by Medicare to the extent of 95 percent with no upper limit. Thus, definitive conclusions are not possible, but it is likely that new and different options will be created in response to the 28 percent employer subsidy for retiree drug benefits.

B. Medigap Insurance

Many Medicare beneficiaries purchase private insurance policies that purport to fill in the gaps in Medicare’s various coverages. These policies, collectively styled “medigap” insurance, come in ten standardized versions, only the three most comprehensive of which (Plans H, I, and J) have any coverage of prescription drugs. Typically, these policies are also the most expensive medigap policies available. And since medigap policies are not subsidized by the federal government, individual policyholders bear the entire cost of these policies in the typical circumstance. In any case, medigap premiums are not guaranteed and are subject to periodic—if not annual—increases. At some point, medigap policyholders may feel the need to drop their policies or perhaps switch to a less expensive, and therefore less comprehensive, medigap policy. In those situations, the new medigap policy is usually one of the seven versions that have no coverage of prescription medications.

Even those medigap policies that cover prescription drugs provide less than what some retirees need. For example, medigap Plans H and I cover prescription drugs but have an annual cap of only $1,250—a figure that has not been adjusted for inflation since medigap policy benefits were standardized in 1990. This cap applies, moreover, after an annual deductible of $250 has been met and a 50 percent coinsurance amount has been applied. That is, a medigap policyholder pays the first $250 of annual drug expenses and then pays half of all further costs until the annual drug tab reaches $2,750. After that point, the policyholder bears all of the additional drug costs!


70. See Frolik & Kaplan, supra n. 9, at 93-95.


72. See Frolik & Kaplan, supra n. 9, at 95.

73. Medigap benefit of $1,250 represents half of drug costs of $2,500, plus an annual deductible of $250, equals total drug costs of $2,750.
The only way to obtain more extensive drug coverage in a medigap policy is to opt for Plan J, the most comprehensive and most expensive medigap policy that is available. This plan has an annual cap of $3,000 with the same $250 annual deductible and 50 percent coinsurance features, so benefits continue until a policyholder’s prescription drug expenditures exceed $6,250 per year. Because of the high premium cost associated with Plan J, however, most people choose some other medigap policy, at least initially. But if a retiree does not obtain a medigap policy within the first six months of becoming eligible for Medicare benefits generally, the private companies that provide medigap policies may decline coverage because of a retiree’s medical condition. As a result, unless a person buys an expensive medigap policy very early in his or her retirement, that person may find that such a policy is unavailable at any price.

In any case, the medigap decision becomes more complicated when drug benefits are available through Medicare Part D. Both alternatives involve out-of-pocket premiums and an annual deductible of $250, but the similarities end there. As noted previously, medigap policies split the costs incurred after the annual deductible 50-50, while Part D picks up 75 percent of the tab. Medigap Plans H and I cap their benefits at an annual drug expenditure level of $2,750, while Part D stops at $2,250. Medigap Plan J continues to provide coverage until annual drug expenditures reach $6,250, after which no further benefits are paid. In contrast, Medicare Part D has no upper limit as such and is actually quite generous once its final tier of benefits is reached; i.e., when annual drug expenditures exceed $5,100. On the other hand, Medicare Part D has that odd coverage gap, or “doughnut hole,” where no benefits are provided for annual drug costs that exceed $2,250 but are less than $5,100. How then to compare these alternatives, especially for Medicare beneficiaries who might face varying drug costs from year to year?

This dilemma is made more complicated still by the Act’s provision that medigap policies with drug coverage may not be sold once Medicare Part D becomes effective. That is, current Medicare beneficiaries who obtain a medigap policy with drug benefits before 2006 may renew that policy thereafter if they choose to do so.

74. Medigap benefit of $3,000 represents half of drug costs of $6,000, plus an annual deductible of $250, equals total drug costs of $6,250.
75. Persons applying for medigap insurance within the first six months of their Medicare Part B eligibility may not be declined because of their medical condition. 42 U.S.C. § 1395ss(s)(2)(A) (2000).
76. For an attempt to undertake such a comparison, see Jack Rogers & John Stell, The Medicare Prescription Drug Benefit: Potential Impact on Beneficiaries 27-29 (AARP Pub. Pol’y Inst. (2004). Such efforts, however, are highly problematic, even if a client’s projected drug costs are precisely knowable in advance, because premiums for medigap policies vary considerably across different localities and even among different insurers within the same locality. See id. at 28 n. 38. Moreover, medigap policies with drug benefits include 8-12 additional unrelated benefits, depending upon the particular plan, and determining the premium cost for the drug benefit alone requires “assumptions” that may be very conjectural. See id. at 28 n. 37.
But after 2005, no one else can obtain a medigap policy with drug benefits; the only medigap insurance that will remain available are policies without any drug coverage. Thus, current Medicare beneficiaries who do not have a medigap Plan H, I, or J have a use-it-or-lose-it opportunity to acquire such a policy during 2005. After that year, drug coverage will no longer be available through medigap policies.

Moreover, a Medicare beneficiary who currently has a medigap policy with drug benefits must choose between renewing that policy or enrolling in Medicare Part D instead. Once Medicare Part D takes effect, any person who enrolls in that program may not also have a medigap policy with drug benefits. Such coverage would certainly be duplicative in large respects, and rarely a sound financial proposition. But the point is that the Act precludes Medicare beneficiaries from hedging their bets by: (a) renewing an existing medigap policy with drug benefits, and (b) simultaneously enrolling in Part D. One, and only one, of these two alternatives is permissible. Furthermore, if a beneficiary does not renew a medigap policy that has drug benefits, that person cannot reinstate that medigap policy after 2005. Thus, the dilemma of choosing Medicare Part D or a medigap policy with drug benefits is fraught with one-time and essentially irreversible decisions.

To make the transition from medigap to Medicare Part D a little less jarring, the Act provides that persons who drop their medigap coverage when they enroll in Medicare Part D may purchase a medigap Plan A, B, C, or F policy on a guaranteed basis. That is, persons in this circumstance cannot be declined one of the four specified types of medigap policies based on their medical condition. That provision is necessary because people in this situation would usually be beyond their first six months of Medicare eligibility, and thus no longer protected by the guaranteed-issuance provision that applies to medigap policies generally.

Still another alternative for medigap policyholders who enroll in Medicare Part D is to renew their existing medigap policy, but without the drug coverage that those policies currently provide. In that case, the Act requires that the premium cost of these truncated medigap policies must be lowered to take account of the reduced benefits being offered.

C. Managed Care Plans

For some time now, Medicare has offered its enrollees the option of managed care plans, sometimes styled Medicare health maintenance organizations, Medicare preferred provider organizations, Medicare + Choice, or most recently, Medicare Advantage. Regardless of their label, these alternative arrangements parallel the managed care trade-off that confronts Americans of any age—namely, in exchange for restricting one’s choice of physicians, hospitals, pharmacies, and other health care

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81. Such a person is also protected from discriminatory pricing of policies or from imposition of a pre-existing condition exclusion. Act § 104(a)(1), 117 Stat. 2163, adding Social Security Act § 1882(v)(3)(A)(ii), (iii).
providers, an enrollee receives Medicare benefits without the customary array of deductibles and co-payments.83 Paperwork is greatly simplified as well.

But the principal reason that Medicare beneficiaries choose a managed care plan is that these arrangements usually include prescription drugs in their package of benefits.84 To be sure, there are often significant limits on this drug coverage. For example, certain medications may not be in the plan’s formulary, while others are available but only at a higher co-pay than other medications.85 Indeed, the majority of Medicare managed care plans provide prescription drug coverage only for generic medications.86 In addition, co-payments are customarily imposed on a per-prescription basis, typically $10 per monthly refill. Most such plans have annual caps on the amount of this benefit, in some instances, as low as $600 per year.87 Moreover, changes are made frequently, and these changes affect current enrollees as well. These changes include removing a medication from the approved formulary, increasing the per-prescription co-payment, imposing or lowering an annual cap on drug benefits, or some combination of all three.

But the biggest change comes when a Medicare HMO or other managed care plan simply discontinues its participation in the Medicare program. Several months’ notice is usually given to current enrollees, but those enrollees often have no other Medicare HMO servicing their geographic area.88 As a consequence, Medicare beneficiaries who previously had satisfactory coverage for their prescription drug costs may find that comparable coverage is no longer available.89 While persons in this predicament could try to obtain a medigap policy, they are undoubtedly outside the six-month window when a medigap insurer may not refuse to cover them for medical reasons. Federal law does provide that persons in this situation can obtain certain medigap policies regardless of their medical condition.90 But the types of medigap policies that are subject to this guarantee—Plans A, B, C, and F—do not include prescription drug coverage in their package of benefits. As a result, many Medicare beneficiaries who thought they had arranged for prescription drug coverage by joining a Medicare HMO

83. See Frolik & Kaplan, supra n. 9, at 97-98.
84. See Nancy Ann Jeffery, Seniors In Medicare HMOs Should Know the Drugs That Prescription Plans Cover, Wall St. J. C1 (May 16, 1997); Melynda Dovel Wilcox, Choosing a Medicare HMO, Kiplinger’s Personal Fin. (Aug. 1996), at 73.
85. See Jeffrey, supra n. 84, at C1.
86. See John Rother, Advocating for a Medicare Prescription Drug Benefit, 3 Yale J. Health Pol’y, L. & Ethics 279, 282-83 (2003).
87. Soumerai & Ross-Degnan, supra n. 20, at 722.
88. See Rother, supra n. 86, at 283; Michael Waldholz, Medicare Seniors Face Confusion as HMOs Bail Out of Program, Wall St. J. D4 (Oct. 3, 2002).
In addition, some Medicare HMOs remained in the program but discontinued their drug coverage. See Milt Freudenheim, Many H.M.O.’s For the Elderly Cut or Abolish Drug Coverage, N.Y. Times C1 (Jan. 25, 2002).
find to their dismay that such is not the case and that replacement coverage may not be available, regardless of cost. This possibility, moreover, becomes less theoretical and more poignant when one examines the enrollment pattern of Medicare beneficiaries in managed care plans. Enrollment in Medicare managed care plans as a percentage of the Medicare population peaked at about 16 percent in 2000 and has declined steadily since then. Presently, only 11 percent of Medicare enrollees participate in a managed care plan.91

Given this history and the availability of drug benefits in Medicare Part D without the restrictions that accompany managed care, the question of whether to join a Medicare managed care plan becomes particularly problematic. The Act requires that all Medicare managed care plans, collectively called Medicare Advantage (MA), offer at least one plan in their service areas that includes Medicare Part D coverage.92 These plans may offer plans with additional drug benefits as well, and some plans undoubtedly will do so by eliminating Part D’s coverage gap, the infamous “doughnut hole.” In any case, MA enrollees who want Part D coverage must receive that coverage through their MA plan.93 That is, they may not obtain a freestanding Part D prescription drug plan like those that are available to persons who stay in traditional Medicare for their basic Medicare coverage.94 Thus, the decision to join a MA plan must now consider whether the drug benefits offered by that MA plan are more appealing than a stand-alone Medicare Part D plan. Indeed, this exclusive sourcing rule might also affect the willingness of managed care providers to offer MA plans at all, since their enrollees must receive whatever drug benefits they get from their MA plan.

V. CONCLUSION

Before the enactment of the new Medicare Act, senior citizens confronted an array of choices for prescription drug coverage. Many had retiree health benefit plans from their former employers, but these plans were subject to premium increases, per-prescription co-payment increases, new restrictions on covered pharmaceuticals, and outright termination. Other people secured private medigap insurance, but such policies were usually expensive, because these medigap policies cover many different aspects of medical expenses in addition to prescription drugs. And prescription drug coverage appears in only the most comprehensive medigap policies.

Many senior citizens joined health maintenance organizations and other managed care arrangements, primarily to obtain coverage of their prescription medications. But these plans often employed restricted formularies and annual caps on allowable drug expenditures. Even worse, many such plans abandoned the Medicare program entirely, leaving former enrollees with no comparable replacement option in many cases. Still other

people obtained their drugs through Medicaid or state pharmacy assistance programs for lower-income individuals. Finally, one in four Medicare beneficiaries had no prescription drug coverage at all.

Onto this disconnected patchwork of drug coverage arrangements, the Act fashions a new Part D program that is widely, though not universally, available. Medicare Part D has some fairly typical features, like monthly premiums and an annual deductible, but it also has some highly unusual features, like a $2,850 coverage gap and a generous 95 percent benefit tier with no annual cap for persons with very high annual drug costs.

This new Part D, moreover, is voluntary, so clients now face even more choices than before. Should they remain in their existing employer-sponsored plan or switch to Medicare Part D? Should they renew their existing medigap policy or enroll in Medicare Part D, knowing that after 2005, new medigap plans with drug coverage are no longer available? Should they secure drug coverage from their managed care plan or enroll in Medicare Part D to supplement traditional Medicare? Finally, should they do nothing at all and simply wait until their medical needs become clearer, even though deferred enrollment in Medicare Part D includes a permanently assessed penalty that is determined by the length of time during which an enrollee had no comparable drug coverage?

This plethora of options inevitably results in client confusion. And that predicament is made worse when one considers that drug needs are not always perfectly predictable. For many Medicare beneficiaries, this aspect is the most problematic. People may know what drugs they need now and what they cost currently, but what will those drugs cost in the future? What if a specific drug that they need is removed from their plan’s formulary, with the result that the client must pay substantially more for that drug? Such a development, which is increasingly common these days, changes the entire calculus of employer-sponsored plans and managed care plans, which typically offer widely differing prices for “included” and “not included” pharmaceuticals, versus medigap and Medicare Part D arrangements, which base their benefits on costs incurred.

The list of imponderables goes still further. What new medications might be developed in the future and what will those new drugs cost? That is, the very nature of pharmacology is that new drugs are being created where none existed before. Will drug benefit plans that limit their coverage to specified medications include these newly developed products, and if so, after how much time passes? Such questions are often critical for persons whose lives may depend on having access to these drug regimens as soon as possible.

Even more fundamentally, what new medical conditions will be diagnosed in the future for a specific Medicare beneficiary? That is, the choices that clients make in securing drug coverage are necessarily tied to their present state of health. Indeed, the entire matrix of drug benefit choices assumes no significant changes in this most important of key variables. But who knows what ailments will befall clients, or what newly discovered diseases they will develop? Thus, a drug plan—be it Medicare Part D or one of the alternatives—may be perfectly appropriate today and be totally inadequate in two years, even assuming no structural changes in the plans themselves or in the cost of medications. Clearly, Medicare Part D provides new options but the central dilemma of selecting the best alternative remains fraught with confusion and uncertainty.
LATE DEVELOPMENTS

After the completion of this article, the Centers for Medicare and Medicaid Services (CMS) posted new information about Medicare Part D to the Medicare website (www.medicare.gov) in anticipation of the program's 2006 roll-out. According to this information, CMS claims that “most prescription drug coverage offered by Medigap policies, on average, is not at least as good as Medicare prescription drug coverage” (emphasis in the original) – even though medigap insurance is specifically listed in the 2003 Medicare Act as a possible category of “creditable coverage.” Consequently, a client who keeps her medigap policy after 2005 and subsequently enrolls in Medicare Part D may be liable for that program's delayed enrollment penalty.

In addition, CMS claims that "most" Medicare Part D plans will utilize restricted formularies with different levels of co-payment for different classifications of covered pharmaceuticals. CMS plans to add a new feature on its website that will allow a client to enter the name, dose size, and dosage frequency of her current medications to locate the most appropriate Medicare Part D plan for her situation. These drug plans, however, may change their formularies in the middle of the year, as long as they provide at least 60 days’ notice of such a change. Thus, the most appropriate Medicare Part D plan at enrollment may become less satisfactory as the year progresses.
A COMPACT TO SOLVE NEW YORK’S LONG TERM CARE CRISIS

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I. AN OVERVIEW OF THE CRISIS

Anyone who has ever encountered the issue of financing Long Term Care thoroughly comprehends the adversarial nature and needlessly complicated process of applying for Medicaid. Indeed, our current Long Term Care system is in desperate need of reform. Paying for Long Term Care is the single greatest hurdle faced by seniors today who are concerned about planning a future that secures their assets and preserves their dignity. Unequivocally, confronting this problem is of the utmost exigency since Medicaid is the only government assistance program that subsidizes Long Term Care, a vital service to countless seniors and members of our society who are disabled.

Long Term Care is essentially custodial in nature and as such, assists chronically disabled individuals with their daily activities of living over a prolonged period as they

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compensate for their loss of the physical and/or mental ability to function independently. Providing assistance with activities of daily life, such as eating, toileting, transferring, bathing, dressing and continence, is the primary function of Long Term Care. Long Term Care is necessary for many seniors and persons with disabilities, but it is also expensive. Medicaid is the most common government program to which seniors and people with disabilities turn. Other options, including private payment and Long Term Care insurance, are often too costly or exclusive. Medicaid covered just under 50% of national spending on nursing home care in 2003 while in stark contrast private insurance covered less than 10%, evidence that Medicaid is essential for seniors and people with disabilities for their Long Term Care needs. However, the primary prerequisite of the current system is an impoverishment process that undermines the American dream. The reality is that most seniors and people with disabilities cannot afford to pay for Long Term Care indefinitely but possess some assets in excess of the stringent Medicaid eligibility limits. Many find themselves in health-care limbo since Medicare does not cover Long Term Care services. This puts seniors and individuals with disabilities in an untenable position with no readily available system to which they can turn. Most people agree that it is inappropriate for American citizens to be impoverished to pay for Long Term Care. As a last resort, people who lack private pay funds and/or do not have coverage under a Long Term Care policy turn to Medicaid. So far, no other alternatives have emerged.

The New York State Bar Association Elder Law Section’s Long Term Care Reform Committee has proposed an alternative method of financing Long Term Care in a way that seeks to help New York State residents access the Long Term Care they need while at the same time curbing the burgeoning costs of the Medicaid Program. This proposal, entitled the Compact, brings a new approach to determining an applicant’s eligibility for government-subsidized Long Term Care services. The idea stems from Gail Holubinka, the primary designer and first director of the NYS Partnership for Long Term Care. Ms. Holubinka provided the initial concept that evolved into the Compact proposal. The Compact Working Group, a subcommittee of the Long Term Care Reform Committee, has devised a novel plan that is both realistic and pragmatic.

This summary of the New York State Long Term Care Compact reflects the views of its authors and is neither endorsed nor rejected by the New York State Bar Association and its Elder Law Section. The Compact proposal is a work in progress. The Compact proposal reflects the continuing painstaking efforts of the Compact Working Group, whose members include Michael Amoruso, Esq., Howard Angione, Esq., Daniel G. Fish, Esq., Gail Holubinka, Howard S. Krooks, Esq., Louis W. Pierro, Esq., and Vincent J. Russo, Esq. This article reflects only the views of the authors, who currently serve as co-chairs of the Compact Working Group.

II. THE FUNDAMENTAL DESIGN OF THE COMPACT

The cornerstone of the Long Term Care Compact is to create a partnership between seniors and people with disabilities and government wherein seniors and people with disabilities will pay a fair share for Long Term Care services with the government’s support. The foundation of the program is the belief that public policy concerning social programs should be a contract between seniors and people with disabilities and the government. Under the contract, the senior or the person with a disability pledges to contribute his/her fair share of the cost burden of Long Term Care services in exchange for retaining a protected amount of personal assets while receiving government assistance.

Under the current Medicaid system, poverty status is required before one can obtain government assistance to pay for Long Term Care. As a result, most seniors and people with disabilities in need of Long Term Care face the Hobson’s choice: spend down the modest estate they have struggled to earn over a lifetime or transfer their assets to children or other relatives voluntarily imposing impoverishment on themselves. However, these transfers result in harsh penalties against the applicant resulting in a period of refused government assistance in accordance with transfer penalty rules. In fact, there is a movement among several states, and even in the United States Congress, to increase the penalties and so-called “look back periods” as a way to solve the Medicaid crisis. What kind of solution is that? Penalties and look back periods leave applicants both destitute and devoid of assistance, worse off then when they began the process. We, as a society, can and must do better.

The Compact would rectify this quagmire, utilizing a rather simple approach. Briefly, once individuals receive a diagnosis of chronic illness, instead of frantically giving away their assets to qualify for Medicaid assistance, they pledge to use a defined amount of their existing assets to pay for their Long Term Care needs. Until this pledged amount is spent, they remain responsible for their own care needs, independent of Medicaid, while retaining full access to the aggregate of their income and assets. Once they have spent the pledged amount, applicants then retain their private pay status but become eligible for the Compact Subsidy to pay for approximately 90% of their Long Term Care costs. At this point, participants would pay 25% of their monthly countable income to the government’s administering agency, using the remaining 75% to pay the portion of their Long Term Care expenses not covered by the Compact Subsidy as well as any ancillary medical expenses.

Under the Compact program, Medicaid becomes the true safety net it was intended to be when it became law in 1965. This Compact proposal would relieve the ever-burgeoning financial stress placed upon the Medicaid system while at the same time empowering individuals to preserve their dignity and quality of life. In developing the Compact proposal, the Compact Working Group members have considered diverse interest groups (i.e., the New York legislative and executive branches, the insurance industry, the consumer, the health care provider, and the

2. Hobson’s choice is a colloquialism, meaning “apparently free choice when there is no choice at all.”
3. For a complete description of the Compact Subsidy, consult infra Phase II, The Compact Subsidy.
Department of Health) and thought through the vast landscape of many issues impacted by the implementation of such a proposal. The Compact proposal has the kind of bi-partisan appeal that will be instrumental to the achievement of a sweeping change in privatization, decreased government spending, and extended government benefits. Above all, the Compact is a common sense approach to our health-care crisis, a growing crisis that looms ever nearer as we charge full speed toward the retirement of the baby-boom generation and the continued aging of the American populace.

At the time of this printing, New York State Senator Martin J. Golden, chair of the Senate Aging Committee, has sponsored legislation to implement the New York Compact for Long Term Care. The foundation of S.3530, the Bill’s title, lies in the same principles outlined herein. The Bill with revisions will be considered in the next legislative session of the New York State Senate.

III. AN IN-DEPTH ANALYSIS OF THE COMPACT

The Compact concept raises a plethora of questions and issues; therefore, we shall address what we consider the most salient points of the Compact proposal. The Compact would work within the established infrastructure of the current Medicaid program and would serve as an alternative to facilitate a less complicated process, eventually reducing the administrative burdens and costs necessary to operate the program.

The Compact consists of two basic phases: 1) the Pledge period, during which time the applicant is referred to as an Eligible Individual, and 2) the Compact Subsidy period, during which time the applicant is referred to as a Compact Participant. We will discuss the highlights of each of the two phases throughout the remainder of this article.

Phase I: The Pledge

Pledge Amount: The pledge amount is the lesser of the regional rate$^4$ calculated for three years (36 months), known as the Maximum Pledge Amount, or one-half the value of the Eligible Individual’s countable assets on the Compact Pledge Date (as defined herein), known as the Dollar Pledge Amount. For example, in New York City the 2005 Regional Rate is $8,870, hence the maximum pledge amount for a New York City Eligible Individual would be $319,320.

An Eligible Individual will have the freedom to elect, at his or her option, the Maximum Pledge Amount even if the Dollar Pledge Amount is lower. The remaining assets not pledged are referred to as the Protected Amount. A Compact Participant will not be required to spend down for Long Term Care services any assets designated as a Protected Amount.

If an Eligible Individual has less than $40,000 in countable assets, the Dollar Pledge Amount is limited to the amount in excess of $20,000, with both figures subject to annual adjustment for inflation. Once the Pledge Amount has been spent for qualified Long Term Care services, the Eligible Individual has satisfied his or her

obligation under the Compact. At this point, the Eligible Individual enters the second phase of the Compact, which provides assistance equal to the Compact Subsidy Amount (discussed later in this article).

Compact Pledge Date: The Compact Pledge Date is the date upon which the Eligible Individual has satisfied the two requirements to enter into the Compact program contract: 1) the individual qualifies for Long Term Care services under the Health Insurance Portability and Accountability Act (HIPAA), and 2) the government’s third party administrator has made a determination of the Pledge Amount and the individual has agreed to the Pledge Amount.

Countable Assets: Unless specifically exempted by the Compact rules, countable assets will continue to include all those defined in § 366 of the New York State Social Services Law, the current Medicaid law in New York.

Homestead Exemption: For purposes of calculating countable assets, a Homestead is exempt regardless of value and regardless of whether the Maximum Pledge or Dollar Pledge Amount is applicable, unless the Homestead was purchased within three years of the Compact Pledge Date. In such event, the Homestead value would be included when computing countable assets unless the Homestead replaces a Homestead sold within one year of the sale of the prior Homestead. If a replacement Homestead was purchased within one year, then countable assets would only include an amount equal to the difference between the gross sale price of the prior Homestead and the net purchase price of the new Homestead.

Look Back Rules: An attractive feature of the Compact’s Maximum Pledge Amount is the elimination of the look back period often associated with the Medicaid program. Under the Compact program, when the Maximum Pledge Amount is pledged, there is no look back period, penalty period, or review of financial documentation, making the program friendly for both the user and the administrator. Only when the Dollar Pledge Amount is pledged would a three year look back period apply, pursuant to which the Eligible Individual would disclose and certify, subject to penalties for perjury, a list of current assets, their values and any asset transfers for less than full consideration within the past three years. Income tax returns, if filed, would constitute the only documents required to be submitted although the government’s third party administrator could request further documentation to verify assets (and values) as well as the amount of any uncompensated assets transferred. While there would be no penalty period established for asset transfers made within the three-year look back period, under the Compact program, any asset transfers made within three years of the Compact Pledge Date would be added back to the sum of countable assets used for the purposes of determining the Pledge Amount.

Spousal Rules: A married couple must disclose total assets without distinction as to who owns the assets. However, agreements between husband and wife regarding asset ownership contained in any pre-nuptial or post-nuptial agreement shall be upheld, unless executed less than three years before the Compact Pledge Date. For the first spouse requiring qualified Long Term Care services, the Pledge Amount would be the lesser of the Maximum Pledge Amount or one fourth of the couple’s countable assets (constituting the Dollar Pledge Amount). Assets of a non-pledging spouse who has entered into a pre-nuptial or post-nuptial agreement made more than three years
prior to the Compact Pledge Date are not considered “countable assets” and would not have to be disclosed under the Compact rules.

If the Maximum Pledge Amount applies, then the Protected Amount would be equal to one-half the couple’s countable assets minus the Maximum Pledge Amount. If the Dollar Pledge Amount applies, then one-fourth of the couple’s countable assets would constitute the Protected Amount. If the other spouse requires qualified Long Term Care services, the Pledge Amount calculation is different. In that case the Pledge Amount of the second spouse would be the lesser of the Maximum Pledge Amount or one-half of the couple’s remaining countable assets after subtracting the first spouse’s Protected Amount and, if the first spouse has not completed his or her pledge, the amount needed to complete the first spouse’s pledge.

On the death of the first spouse, if the Protected Amount passes to the surviving spouse, it is not included in computing the surviving spouse’s countable assets when applying for Compact coverage. Furthermore, if maintained in a segregated account the growth and income of the Protected Amount are also protected. The surviving spouse of a Compact Participant is not required to exercise a right of election under § 5-1.1-A of the Estates Powers and Trusts Law if the Will of the first spouse leaves the Protected Amount to someone other than the surviving spouse.

Advisory Committee: Senate Bill S.3530, as introduced on March 21, 2005 to the New York State Senate, is the first attempt to codify the Compact proposal. The Bill provides a system for the creation of an Advisory Committee to address the many concerns expected to arise through implementation of the Compact program (especially pertaining to the unpredictable nature of the issues that could arise in the spousal context). The main purpose of the Advisory Committee is to provide for the continued development of the Compact program once implemented. The proposed Committee would be comprised of seven appointees. Individuals on the Advisory Committee would operate under the auspices of the Compact Program Commissioner and would receive no compensation for their work besides that which covers the expenses of their duties.

Estate Recovery: Once the Maximum Pledge or the required Dollar Pledge Amount has been satisfied, there will be no estate recovery of any Protected Amount or the Homestead.

Annuities: The Compact program has three basic rules concerning the treatment of annuities in the Pledge process:

Annuities Purchased Within Three Years of Compact Pledge Date – An annuity in permanent payout status purchased within three years of the Pledge Date is a countable asset for Pledge purposes. However, payout

6. The Advisory Committee would be comprised of the following: Two members from the Elder Law Section of the New York State Bar Association (to include the Chair of such a section or a designee appointed by the Chair who shall serve ex-officio); two members from statewide advocacy groups that deal with senior issues; two members with at least five years experience in the development of Long Term Care insurance products; and one member with at least five years actuarial or accounting experience in health insurance matters.
amounts are not treated as countable income later on in the Compact process when the Eligible Individual has satisfied the Pledge Amount and becomes a Compact Participant, eligible for Compact Subsidy payments.

Annuities Purchased Prior To Three Years of Compact Pledge Date – In contrast, an annuity is not a countable asset if a level payment schedule has been in force for three or more years before the Compact Pledge Date. However, payout amounts are treated as “countable income” later on in the Compact process when the Eligible Individual has satisfied the Pledge Amount and becomes a Compact Participant, eligible for Compact Subsidy payments. The monthly amount of a level payment schedule would be based on the value of the assets invested, the anticipated interest, and the person’s life expectancy as established by the Internal Revenue Code and the applicable Treasury Regulations promulgated thereunder.

Annuities Not in Permanent Payout Status – Annuities that are not in a permanently established payout status for three years prior to the Compact Pledge Date are treated as countable assets for the purposes of calculating an Eligible Individual’s Pledge Amount.

Irrevocable Trusts: The value of any asset placed in an Irrevocable Trust for less than full consideration within the three-year look back period prior to the Compact Pledge Date would be included in the computation of countable assets to determine whether a Maximum Pledge Amount or Dollar Pledge Amount is applicable.

Pre-Plan Funerals: A Pre-Plan funeral purchased by an Eligible Individual for him or herself, a spouse, or children with disabilities, would not be included in the computation of countable assets if purchased before fulfillment of the Compact Pledge. A Pre-Plan funeral purchased after the Compact Pledge Date but before the Compact Pledge has been fulfilled, results in the downward adjustment of the Compact Pledge Amount to account for the expense.

Debts: All debts, including but not limited to outstanding amounts on credit cards, auto payments, mortgages, home equity loans, reverse mortgages and the like, would be deducted from the countable assets for purposes of determining the applicable Pledge Amount.

Long Term Care Savings Account (LTCSA): Individuals who applied for Long Term Care Insurance, and were denied coverage due to the underwriting process would have the option, under the Compact program, to place a defined amount of money in a Long Term Care Savings Account (LTCSA) each year. The proposed computation of the maximum annual deposit amount is a sum not to exceed twice the current annual IRA contribution limit (which is presently $4,000) allowed under the Internal Revenue Code and applicable U.S. Treasury Regulations. Amounts placed in the LTCSA annually would be eligible for the same tax deductions available to those who contribute to an IRA account. In addition, the amount in the LTCSA would not count when computing that individual’s countable assets. There would be no federal or state income tax consequences for the expenditure of funds from the LTCSA to fulfill the Pledge Amount.

When the need for care arises and an Eligible Individual makes a Compact Pledge, LTCSA funds are the first assets expended to meet the Pledge Amount. If
funds placed into the LTCSA are insufficient to fulfill the Pledge, the Eligible Individual would be required to use a portion of his/her unprotected countable assets. If any funds remain within the unprotected countable assets upon completion of the Compact Pledge, those funds would be added to the Protected Amount as the Eligible Individual entered Phase Two of the Compact Program (becoming a Compact Participant, eligible for Compact Subsidy payments). If a LTCSA holder dies without using some or even all of the funds placed into the account, the remaining balance would be payable to the state without any federal or state income or estate tax consequences.

**Asset Management During Pledge Amount Spend Down:** Individuals who have made Pledges will have the option of placing funds sufficient to fulfill their Compact Pledge into segregated set-aside accounts comparable to those established to assure Medicare’s reimbursement in workers’ compensation cases. This is the same principle established in New York State Partnership for Long Term Care Policies. Compact participants may make uncompensated transfers from the Protected Amount (the amount remaining after the Pledge Amount is satisfied), although they will be responsible for assuring that their total assets do not fall below the amount needed to fulfill a Compact Pledge.

**Inheritance Received After Pledge Amount Is Determined:** If a Compact Participant receives an inheritance after the Pledge Amount has been determined and the Compact Pledge Date has passed, the calculation of countable assets and the Compact Pledge Amount is not adjusted to reflect the acquisition of new assets. This is the same principle that applies in New York State Partnership for Long Term Care Policies. If the Compact Participant is unmarried, the inherited funds are added to the Protected Amount. For a married couple, one-half of the additional funds would be added to the Compact participant’s Protected Amount and the other half would be considered part of the Compact spouse’s countable assets should he/she later apply to participate in the Compact Program. If both spouses have already fulfilled his/her pledge, then the inheritance is added to the Protected Amount of each spouse in equal amounts.

**Disqualification:** Under the proposed New York legislation, Senate Bill S.3530 clearly articulates grounds for disqualification from the Compact Program in a manner that seeks to penalize with fairness. Eligible Individuals who fail to fulfill their Compact Pledge have breached the contract. Breaching parties are denied Compact Program benefits. However, such individuals would retain the right to apply for Medicaid if eligibility for that program could otherwise be established. Eligible Individuals who are found to have engaged in deceptive or fraudulent practices with respect to fulfilling a Compact Pledge would be disqualified from the Compact Program. In such a case, a fulfilled Compact Pledge would not be recognized, as the individual would no longer be considered eligible to be a participant in the Compact Program. Senate Bill S.3530 states that any individual who knowingly makes a false statement or representation, or who by deliberate concealment of any material fact, or by impersonation or other fraudulent device, obtains or attempts to obtain or aids or abets any person to obtain coverage under the Compact Program to which such individual is not entitled shall be guilty of a class A misdemeanor, unless such act
Phase II: The Compact Subsidy

Compact Subsidy: Once an Eligible Individual has fulfilled his or her Pledge obligations, the government commences its coverage of qualified Long Term Care services. The Compact Subsidy Amount is the amount of money the government’s administering agency would pay toward covered services provided to the Compact Participant. This amount is equal to the Medicaid Rate applicable to individuals receiving standard Medicaid coverage. However, providers could charge Compact Participants a Compact Rate which can be up to 110% of the Compact Subsidy Amount. Thus, the government’s liability for qualified Long Term Care expenses is limited to the Medicaid rate, yet providers may charge Participants at the Compact Rate, a figure that is higher than the Compact Subsidy Amount, but lower than private-pay rates. The Compact Participant is responsible for making whole the Co-Pay Amount, which is the difference between the Compact Rate charged by the provider and the Compact Subsidy Amount paid by the government.

Treatment of Income: Once an Eligible Individual has fulfilled his or her Pledge obligation, the second phase of the Compact Program, known as the Compact Subsidy period, commences. The Compact Participant would be required to pay 25% of his/her Monthly Countable Income to the government’s administering agency for the Compact Program. The remaining 75% of the Compact Participant’s Monthly Countable Income would constitute his/her Monthly Income Allowance, an amount representing the minimum monthly income that the Compact Participant could retain. A portion of this Monthly Income Allowance would be used to meet the Participant’s Co-Pay obligations (discussed above in “Compact Subsidy”), subject to a floor defined as the Minimum Monthly Income Allowance. Co-Pay obligations would cease at the point where the balance remaining from the Participant’s Countable Income fell below this figure.

Countable Income: Monthly Countable Income would include those sources of income identified in § 366 of the New York State Social Services Law (the current Medicaid law) excluding Exempt Income and Income Deductions allowed under the Social Services Law. For example, Exempt Income would include Agent Orange payments or Reparation payments while Income Deductions would include payments for health insurance premiums for Medicare Supplemental health insurance policies. With respect to annuities, payments received from a level payment annuity purchased within three years before the Compact Pledge Date would be treated as a Countable Asset rather than as Countable Income.

The Role of Long Term Care Insurance: The Compact Pledge Amount can be fulfilled in whole or in part with Long Term Care insurance. While certain individuals cannot afford or obtain (for medical reasons) it, Long Term Care insurance can still play a vital role in the Compact program. If a Compact Participant remains eligible for
further Long Term Care insurance payments after fulfillment of the Compact Pledge, the policy would serve as a “secondary coverage” for services not paid for by the Compact Subsidy.

III. CONCLUSION

The efforts of the Compact Working Group in developing the New York State Long Term Care Compact are by no means complete or etched in stone. However, we hope that the summary of the program contained in this article will foster a better understanding of the Compact Program and that this article will serve as a model for other states trying to deal with the burgeoning costs of their Medicaid programs. The authors are committed to continuing their exploration of the Compact proposal. The authors will produce a future article with examples of how the Compact proposal would work in common real-life situations. The bottom line is that the time has come to take a bold step toward reform; the cost of doing nothing to help America’s seniors and persons with disabilities is simply too great. Long Term Care is vital and our most vulnerable citizens should not have to impoverish themselves to obtain needed services. America’s senior citizens have consistently made contributions to our society, building this country into a world leader; we owe them a future that holds more than impoverishment and degradation. We are a nation of can-do people who see a problem and devise a solution that seeks to address the concerns of many. The New York State Long Term Care Compact is the result of that culture. We feel that the Compact, if properly implemented, would solve many of our Long Term Care problems and, most importantly, help our seniors and people with disabilities live in peace and with dignity. We owe this solution not so much to politicians and legislators, but to our own parents, friends, and all those who need Long Term Care. The Compact program is an idea whose time has come. It can work. It is time we put our energy together to change the system for the better before we become the very same seniors who find ourselves in need Long Term Care services with no way to pay. This is indeed one issue that is not going away.

The authors wish to acknowledge the efforts of the following individuals, all of whom serve as members of the New York State Bar Association Elder Law Section Compact Working Group and who have worked tirelessly to develop the Compact proposal: Michael Amoruso, Esq., Howard Angione, Esq., Daniel G. Fish, Esq., Gail Holubinka, and Louis W. Pierro, Esq.

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ELDER CLIENTS WITH DIMINISHED CAPACITY: NAELA’S RESPONSE TO SPECIFIC CASE APPLICATIONS AND ITS DEVELOPMENT OF ASPIRATIONAL STANDARDS THAT MAY CROSS PROFESSIONAL ORGANIZATIONAL BOUNDARIES.*

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I. INTRODUCTION

NAELA members, elder law attorneys and trust and estate counsel have for some time dealt with the aging of our society; a highly visible demographic forecast of the early ‘80s. The reality of the forecast impacts financial services professionals, banking and trust professionals, accounting professionals, insurance professionals and legal professionals with striking similarity. Regardless of whether or not they are specialists lawyers are seeing an increasing number of older prospective clients with diminished capacity, while at the same time being confronted with the dilemma of existing clients whose capacity has begun to diminish. These new wrinkled faces of capacity come in countless variations, often hidden by cosmetic makeovers that project youthful visual images and well-scripted sound bites of single words and phrases that give the appearance of informed verbal understanding. Many elderly clients are presenting illusions of mental competence sufficient to exercise informed consent in the execution of legal documents and in declaring client-lawyer representation. Banking, financial and accounting professionals often refer these elderly clients to

1. Recent articles have pointed to the change in customer characteristics, advising readers on how to market to them. See e.g., Older Consumers: Destroying Market Myths www.thematuremarket.com (2005); see also George P. Moschis, Marketing to Older Adults – An Updated Overview of Present Knowledge and Practice, Journal of Consumer Marketing 20(6), 516-525, The Georgia State University, Robinson College of Business, Center for Mature Consumer Studies (2003).
2. See ABA 2004 MRPC 1.18, Duties to Prospective Client, infra n. 14, at 69-71.
3. For the sake of brevity, prospective and current client will be identified throughout the article as “client.”
Development of Aspirational Standards

2005

lawyers. At the point of referral, it is usually not clear to the lawyers whether or not the capacity of the clients have been determined by the professionals making the referrals, or on what ethical basis an understanding of representation has been determined.

II. WHAT CONFRONTS THE PROFESSIONAL

This article begins with a summary examination of the professional’s position, and reviews, where available, the ethics and codes by which the professionals and their professional organizations respond to customers and clients. The article then reviews examples of how the National Academy of Elder Law Attorneys (“NAELA”) and other legal organizations are addressing the diminished capacity issue, and offers an explanation of how future guidance available to lawyers should help those in other professions. Two tools being developed are worth reference: First, NAELA’s development of Aspirational Standards. NAELA is asking its members to commit to its higher level of practice that has been published in recent months. Consider two illustrations:

First Illustration - The Professional

Betty had an initial appointment with Professional regarding her current financial portfolio. She was accompanied by one of her three children, Debbie. Betty explained that she was a widow, needing to consider asset preservation and estate planning and asking to hear more about new financial products that might better fit her status and age.

After reviewing basic facts and information, Professional explained a variety of options and products. Betty quipped that Professional was talking way above her head. Professional replied that everything would be presented in writing for her to carefully consider and that there would be a period in which she could choose to reject the purchase of products.

As Professional followed with a series of other questions, Betty began contradicting herself, seeming somewhat confused. Debbie intervened each time, answering for Betty. After Debbie answered several questions, Professional tried to redirect his questions to Betty, rephrasing them so that Betty only had to answer yes or no. However, when Debbie did not answer a question, Betty would answer incoherently.

Professional knew that Betty was struggling to understand just what she was doing.

4. See NAELA Aspirational Standards in attachment “A” at the end of this article. At the time of the writing, of this article, the commentaries to the NAELA Aspirational Standards were still in development under the supervision of Gregory S. French, Chair of the NAELA Professionalism & Ethics Committee. French is scheduled to publish an article on the Aspirational Standards and the commentaries in a future issue of the NAELA Journal.
Analysis

While the codes of ethics of many professional groups do not address issues of competence of customers or clients to make decisions based on informed consent, at least one professional group indirectly guides its members through responsible inquiry of the customer or client to assure that there is an informed understanding of the services or products being purchased. In the illustration above, Professional gathered enough information, and had sufficient specific dialogue with Betty to confirm that Betty may have diminished capacity such that she might not be able to exercise informed consent. Is this situation becoming an increasing occurrence? What should Professional do in this situation? Does the answer differ between professions? As the lack of capacity becomes starkly apparent, so obvious that it is without doubt, does Professional’s ethical duty itself become apparent?

Without a doubt, the above illustration is occurring in increasing numbers, and these situations will compound in volume and complexity as the Baby Boomers finish being the “sandwich generation” and focus on their own retirement needs. Each professional answers the question of what he or she should do based on weighing critical factors, and applying the organization’s or profession’s ethical rules. One response is shown here:

First Illustration - Continued

Because of Professional’s observations during the meeting, he suggested that Betty make an appointment with her lawyer to be sure she had her financial and health care powers of attorney up-to-date.

Analysis

In the continuation of the first illustration above, Professional exercised a multidisciplinary approach, bringing a lawyer into the process of assessing Betty’s legal competence to execute advance directives. If, however, Professional was confronted with the more difficult situation of Betty presenting with significant diminished capacity, Professional should consider bringing a medical, social work or healthcare professional into the process. This could very well cost Professional the
sale, or a commitment to a purchase of services. However, any action taken after the presumption of incompetence is raised crosses the ethical divide. If Professional has Betty execute documents when he believes she cannot provide informed consent, then such action may amount to fraud or an unfair and deceptive trade practice. The real problem is that the ethical boundary is never obvious; there is rarely a bright line. That is why there are countless professionals crossing that ethical divide all the time as they struggle under the pressure and stress to produce and meet goals. Consider the final installment of the first illustration; it may prove instructive.

First Illustration – Final Result

Because of Professional’s observations during the meeting, he suggested that Betty make an appointment with her lawyer to be sure she had her financial and health care powers of attorney up-to-date. Debbie answered for Betty that she was attorney in fact and agent. Debbie then asked Betty if that was right, and Betty quickly agreed. Debbie turned to Professional and said that her brother and sister lived out of state, but were in complete agreement with what Betty wanted to do. Betty added that all of her children loved her and everything was just fine. Professional then had Betty and Debbie sign all documents for the purchase of the financial products.

Two days later, Professional received a phone call from Betty, declaring that she was “exercising her right of rescission” and canceling the purchase of the financial products. In the background, Professional could hear a voice yelling instructions to Betty. Professional then insisted that he would immediately come out to the house to discuss rescission and sign documents. At the house, Betty and her son, Tom, greeted Professional; Debbie was nowhere to be found. When Professional asked about Debbie’s whereabouts, Tom took over the conversation and said that he was his mother’s attorney-in-fact as of that morning.

III. The Lawyer

An understanding of how the legal profession addresses the ethical dilemma of a client’s diminished capacity may guide other professional organizations as their members ask them what to do.9 This has been the focus of NAELA and several

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9. At the time this article was being written, the ABA Commission on Law and the Elderly (ABA-COLA) and the APA were about to publish their joint publication on assessing capacity. See Jennifer Moye, Evaluating the Capacity of Older Adults: Psychological Models and Tools, 17 NAELA Quarterly 3 (Summer 2004).
organizations within the legal profession for several years.\textsuperscript{10} Consider the second illustration:

\textit{Second Illustration – The Lawyer}

As Professional suggested, Betty had a consultation appointment with Attorney regarding her current situation. Debbie again accompanied her. Betty explained her situation to Attorney as she had explained it to Professional. After reviewing the same basic facts and information, Attorney began by asking Betty who his client was. Further discussion between them produced an agreement that Betty was Attorney’s client for the consultation.

Further into the consultation, Attorney explained that advance directives were a necessary alternative to guardianship, clarified the risks involved and discussed other reasonable available alternatives. Betty responded, as she did previously to Professional, that Attorney was talking way above her head. Attorney replied that everything would be presented in writing for her to carefully consider and that he would give her written confirmation of any further engagement. When Attorney asked about sharing confidences with, and sending copies of all correspondence to the other children, Betty first looked at Debbie before directing him to only share confidential information with Debbie for the time being.

\textbf{Analysis}

At the inception of the client-lawyer relationship, elder law and trust and estate attorneys must generally deal with issues including competence, communication, confidences and loyalty.\textsuperscript{11} Initially, the ethical analysis of the client-lawyer relationship is not difficult as long as the lawyer knows to pose the question, “Who is

\textsuperscript{10} See the many published manuscripts, articles and symposium manuals of NAELA, www.naela.org (last accessed July 31, 2005); the National College of Probate Judges, www.ncpj.org (last accessed July 31, 2005); the American College of Trust and Estate Counsel, www.actec.org (last accessed July 31, 2005); and the ABA-Real Property Probate and Trust Section, http://www.abanet.org/rppt/home.html (last accessed July 31, 2005).

\textsuperscript{11} See Geoffrey C. Hazard, Jr. and William Hodes, \textit{The Law of Lawyering} (2 ed. Aspen Law & Business 1996) (Supp. 2004), Pt. 1, at 1, explaining that the four duties (competence, communication, confidentiality and loyalty) of the core principles of the law of lawyering run to the client, and noting that The Kutak Commission symbolized the primacy of client interests by reversing the common “lawyer-client” reference; see also ACTEC Commentaries on the Model Rules of Professional Conduct (3 ed. ACTEC Foundation 1999). The ACTEC Commentaries have as their themes (1) the relative freedom that lawyers and clients have to write their own charter with respect to a representation in the trusts and estates field; (2) the generally nonadversarial nature of the trusts and estates practice; (3) the utility and propriety, in this area of law, of representing multiple clients, whose interests may differ but are not necessarily adversarial; and (4) the opportunity, with full disclosure, to moderate or eliminate many problems that might otherwise arise under the Model Rules.
the client?” to those making the initial appointment. As shown in the illustration above, the answer should come from the client. The client is often the elderly person seeking legal advice regarding future long-term care issues and the balance between asset preservation and quality of life. With other family members in the room, however, the initial contact becomes more complicated, especially when the older person seeking legal services has diminished capacity. Inter-generational or family unit representation is not within the scope of this article; however, what is within its scope is acknowledging and addressing the stress that presses the lawyer against the ethical boundaries of lawyering as the client-lawyer relationship begins.

Before representation is established, there should be confirmation that the prospective client has sufficient competence or capacity to enter into the client-lawyer engagement. In the second illustration, Attorney took this first step. Once client identification is confirmed, the broader spectrum of an elder law engagement usually addresses quality of life and quality of available services to the elder. Concomitant with a review of medical and health care needs, the engagement may also cover issues and strategies such as long term care insurance, estate and asset protection planning for tax or government benefits consideration, options that may lead to transition into assisted living or nursing home environments, or even change of residency, domicile and state citizenship.

Elder law attorneys often assess the client’s competency to engage counsel, ensuring that the client has sufficient cognitive function to exercise informed consent.


16. See Fleming and Morgan - Lawyers’ Ethical Dilemmas, supra n. 15, at 750-751; see also Michael A. Stratton, Hit Hard, Not Low, TRIAL, 60 (September 2003).

17. See William E. Adams and Rebecca C. Morgan, Representing the Client Who Is Older in the Law Office and in the Courtroom, 2 Elder L. J. 1, 2 (Spring 1994).

18. Id.
to enter into the engagement contract.\textsuperscript{19} As a result, many elder law attorneys have included as an element within the scope of prospective representation a reasonable screen, assessment or calculation of client capacity.\textsuperscript{20} Acting with sensitivity, reasonable legal competence and diligence, elder law attorneys assess client capacity, while honoring client confidences.\textsuperscript{21}

At this initial stage of the second illustration, the client-lawyer relationship presented is rather benign, if not typical. Attorney has taken appropriate steps to gain an initial understanding of the client, eliciting from Betty what seem to be her independent decisions with her informed consent. The recently revised Rules of Professional Conduct of the American Bar Association (“hereafter ABA Model Rules”) set out new definitions and edited current rules addressing this area of client capacity.\textsuperscript{22} Under new ABA Model Rule 1.0(e), defining informed consent, Attorney has made clear his obligations to Betty with respect to obtaining her consent, possible conflicts of interest and the scope of representation.\textsuperscript{23} This is where the new rule definition is more practical. The new rule definition replaces the concept of “consent after consultation” with the somewhat more familiar concept of “informed consent.” As defined, “informed consent” denotes agreement “after the lawyer has communicated adequate information and explanation about the material risks of and reasonably available alternatives to the proposed course of conduct.”\textsuperscript{24}

In the initial part of the consultation appointment, Attorney has followed this rule, going beyond that which is mandatory by offering a written contract that confirms Betty’s consent.\textsuperscript{25} Ordinarily, a client-lawyer situation such as this does not require the client to sign a written agreement. This remains the rule in spite of the ABA Ethics 2000 Commission’s recommendation to the contrary.\textsuperscript{26}

\begin{itemize}
\item \textsuperscript{19} See Green – Ethical Issues, supra n. 13, at 18-21.
\item \textsuperscript{20} See Fleming and Morgan, Lawyers’ Ethical Dilemmas, supra n. 15, at 750-751.
\item \textsuperscript{21} See Jeffery N. Pennell, Ethics, Professionalism and Malpractice Issues in Estate Planning and Administration, 2 (ALI-ABA 2002).
\item \textsuperscript{22} See ABA Center for Professional Responsibility, 2004 Model Rules of Professional Conduct, (hereafter ABA 2004 MRPC) http://www.abanet.org/cpr/mrpc/mrpc_home.html (ABA 2004). Adoption of the Model Rules in virtually every state, whether in whole or in part, is the broadest disciplinary mandate that is uniform across the country; see also Pennell, Ethics, Professionalism and Malpractice Issues in Estate Planning and Administration, id., at 19.
\item \textsuperscript{23} See ABA 2004 MRPC 1.0(e) Terminology – Informed Consent, id., at 7.
\item \textsuperscript{24} Id., and Comments (6) and (7), at 9-10.
\item \textsuperscript{25} This is adhering to the higher habit of practice of memorializing the engagement in a written document, such as a letter confirming engagement or a more formal retainer agreement signed by the client. See NAELA Aspirational Standards, supra n. 5.
\item \textsuperscript{26} This is one of the very few places where the ABA House of Delegates parted ways with the ABA Ethics 2000 Commission. The Commission believed that the time had come to upgrade the preference of a writing of the scope of the representation and the basis or rate of the fee and expenses to an across the board directive. Where one of the greatest areas of misunderstandings and disputes is found in lawyer fees, the Commission sought to maximize understanding by requiring a written agreement. A divided House of Delegates found the time had not come to require across the board writings. See http://www.abanet.org/cpr/e2k-summary_2002.html. (last accessed July 17, 2005).
\end{itemize}
Second Illustration – The Lawyer Continued

As the Consult Proceeds, Everything Begins to Change

As Attorney followed with a series of other questions, Betty contradicted herself and seemed somewhat confused. Debbie intervened, answering for Betty. After Debbie answered several questions, Attorney redirected his questions to Betty and rephrased them so that Betty only had to answer yes or no.

Toward the end of the conference, Attorney asked Betty who she wanted to be her agent on financial and health care powers of attorney. Debbie answered for Betty that she would be attorney in fact and agent. Debbie then asked Betty if that was right, and Betty quickly agreed. Debbie turned to Attorney and said that her brother and sister lived out of state, but were in complete agreement with what Betty wanted to do. Betty joined in saying how all of her children loved her and everything was just fine. Attorney then stood up, inviting Debbie to return to the reception area while he spoke with Betty separately. Debbie insisted that was not necessary, elevating her voice, and elevating Betty’s agitation as well. Attorney asked Betty if she would talk to him separately. Debbie retorted that Betty could not talk to him without her being present.

Analysis

The analysis turns to Attorney’s first impression of Betty’s capacity. Obviously, he made the decision that Betty had sufficient capacity to engage him for the initial conference because he continued the conference believing that she was his client. After Betty showed greater confusion, Attorney could have conducted an informal screen, assessing from a legal position whether Betty’s basic understanding was sufficient for her to make choices.

In the summer issue of the NAELA Quarterly, Jennifer Moye, presents an article regarding diminished capacity and serving elderly clients. Moye’s article, Evaluating the Capacity of Older Adults: Psychological Models and Tools,\(^\text{27}\) reviews the “work in progress” of what she describes as the American Bar Association’s and the American Psychological Association’s examination of the graying of America, the increasing prevalence, with age, of diseases affecting cognition, the need for attorneys to do some sort of preliminary and informal assessments of capacity, and the dilemmas presented by revised ABA Model Rule 1.14 (Client with Diminished Capacity). This examination will soon be producing a handbook that provides guidance to non-medical, psychological or health care professionals when addressing client capacity.\(^\text{28}\) Even though the handbook is not available, Attorneys, and other professionals as well, currently have guidance from other sources in making an informal assessment.

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\(^{27}\) See Moye, Capacity, supra n. 10, and accompanying text.

\(^{28}\) Id.
There are many informal assessments, screens and other instruments from which to choose. Some authors suggest that elder law attorneys use their own simple screening tool or tools. For client capacity indicators, Professor Larry Frolik offers a one page, six section questionnaire that is a good beginning. For mental ability assessment, functional assessment and safety assessment, in the Elder Law Forms Manual, Harry Margolis has developed three simple assessment tools that construct questions regarding mental ability, basic activities of daily living and self help determination, and concerns for physical safety of the client. For client capacity assessment, Michael Gilfix offers a client capacity assessment form directed contextually, rather than globally, based on a general assessment of capacity. The form offered in his forms manual is developed within the context of estate planning. Gilfix suggests that for different issues or objectives, the elder law attorney should construct the questions relevant to the subject, and critical to development of a particular legal document, or accomplishment of a particular goal. It is interesting to note that at the bottom of the form, Gilfix suggests that the assessment should be given in a way that eliminates distractions, that the assessor speak loudly and clearly, and that the assessment be given based on the assumption “that you will have a competent client”. Over the years, several, more sophisticated, instruments have been designed for non-medical, non-psychological, and non-health care professionals to screen or preliminarily assess the ability of a client or family member to exercise informed consent. The instruments qualify in broad categories the client’s ability to exercise sufficient cognitive function in order to maintain a threshold level of capacity necessary to access alternatives to guardianship or conservatorship. These instruments include The Legal

29. This portion of the article was part of a larger manuscript of author Johns. See A. Frank Johns, *Multiple and Intergenerational Relationship*, The Professional Lawyer, 7, 18-21 (ABA 2001).
33. There are those, however, who believe that such a screening process or preliminary assessment is outside the realm of the practice of law and should not be a part of the attorney’s office practice. There has also been criticism of the instruments, specifically whether or not the screens and assessments sufficiently examine the ability of an individual or a client to function, or seek assistance to function in life. Regardless of the instrument used, attorneys may be too far out of their expertise to deal with such a complex area. It has been difficult even for psychiatrists and neurologists. See J. Aker, A. Walsh, J. Beam, *Mental Capacity - Medical and Legal Aspects of the Aging*, (Shepard’s/McGraw Hill, Cum. Supp. 1993), Ch. 4, Diagnosis of Brain Damage; cf., Baird Brown, *et al.*, *Mental Capacity - Legal and Medical Aspects of Assessment and Treatment*, Mental Capacity, § 7.06 Mental Status Exam: (2 ed. Shephard/McGraw Hill, 1994).
Capacity Questionnaire (LCQ); the Mini-Mental State Examination (MMSE); the Client Capacity Screen (CCS); and the Behavioral Dyscontrol Scale (BDS). Moye makes clear that while lawyers and other professionals are capable of screening or informally assessing the capacity of a client, they should never attempt full-blown psychological testing or evaluation.

In the second illustration, the more conventional legal practice would be for Attorney to advise Betty to first see her doctor, or seek psychological, psychiatric or geriatric evaluation. This is also the point at which more experienced elder law attorneys would insist that Betty be interviewed in private, outside of Debbie’s influence.

Even without a screen, Attorney concluded that Betty had diminished capacity. Equally important, he further concluded that Debbie was exerting undue influence over Betty. Based on this set of facts, the ABA Model Rules allow Attorney certain discretion, especially in the context of disclosing confidential client information to prevent harm to Betty.

What follows is the final addition to the illustration played out with Attorney taking a different action.

Second Illustration – End Of The Story

Attorney Action and Client Reaction

Attorney sensed that Debbie was influencing Betty’s decisions and that Betty’s capacity was diminished. He explained his conclusion that he could not adequately represent Betty and that it would be best if she sought other counsel.

34. See Baird Brown, Determining Clients’ Legal Capacity, IV The ElderLaw Report, no. 7, at 1 (Little Brown 1993). (Brown provides a careful explanation of the LCQ, a guide for giving the LCQ and an answer sheet for scoring the LCQ; see also, Baird Brown, et al., id., Mental Capacity, § 5 Assessment of Capacity. (This is the second edition of the Walsh text.).

35. See M. Folstein, S. Folstein, P. McQue, Mini-Mental State: A Practical Method for Grading the Cognitive State of Patients for the Clinician, 12 J. of Psychiatric Research, 189-198 (1975). The MMSE has been identified as the most widely used test with excellent test and retest reliability.

36. See Steven Fox, Suzanne McNeely and Charles Ingman, A Client Capacity Screen: A Tool for Evaluating Mental Capacity, 4th NAELA Symposium, § 11 (1992). The authors note that the client capacity screen is not a replacement for the use of medical professionals, but provides a structure for assessment, which assures relevant information, and provides the attorney with an easy and accessible method of documenting the file regarding such assessment.

37. See Baird Brown, Determining Client’s Legal Capacity, supra n. 35, (Brown explains that the BDS is a standardized test designed to assess the integrity of the frontal lobes of the brain.).

38. See Moye, Capacity, supra n. 10, at 6.

39. See NAELA Aspirational Standards, supra n. 5, Standards approved by the NAELA Board strongly advises NAELA members that this is a best practice to which all members should aspire.

40. See ABA 2004 MRPC 1.6(b)(1) and 1.14(b), supra n. 23, at 22.
No fee was paid. As Betty left with Debbie, Attorney saw what he thought were bruises on her arms. From his office window, Attorney could see the firm parking lot. There he saw Debbie arguing with Betty, shoving her into the car and recklessly racing down the street.

Two days later, Attorney received a call from Betty’s son, Bob. Bob wanted to know what happened at the meeting. Attorney told him everything; especially how Attorney saw what he suspected was Debbie’s abuse of Betty in the parking lot. Bob said he would hire Attorney to prepare the powers of attorney and that he would fly into the city to arrange for Betty to sign them. Attorney agreed, assuming that Betty had never been his client.

Analysis

To paraphrase prominent American figures early in the last century, now this is another fine mess Attorney has gotten himself into. Experienced elder law practitioners, however, have been through this scenario and worse. These experienced attorneys would not necessarily respond as Attorney did, but parent-child problems, including elder abuse, are often present, and are always difficult.

In this illustration, Attorney has made the wrong assumption. New ABA Model Rule 1.18 – Prospective Client provides guidance relating to situations in which the lawyer has had sufficient contact with the prospective client and the prospective client has divulged enough information for confidentiality issues and conflicts of interest are in play. In this illustration, Betty has provided Attorney with important information that must be maintained as confidential client information and communication. She has also committed to a client-lawyer relationship, at least through the initial consultation appointment. If Bob and Attorney want to assume that Bob is Attorney’s client, then under ABA Model Rule 1.18, Attorney should have determined if there were material conflicts in Attorney’s representation of Bob with respect to Betty. If there were material conflicts, Attorney should first have informed Betty of those conflicts, and then asked her to sign a written authorization for Attorney to represent Bob. If Bob will not be the client, but will pay the legal fee for Betty, then Attorney must comply with ABA Model Rule 1.8(f) that deals with such fee payments. By telling Bob everything prior to receiving Betty’s informed consent, Attorney has violated Betty’s right to confidentiality.

In the context of client representation and confidentiality, the illustration should be simple and the analysis easy because there is only one client - Betty. At the consultation appointment, Attorney and Betty were in agreement that Attorney was representing Betty, and not representing Debbie or the other children. No matter how
much divulging the information would help Bob and Betty, Attorney should have maintained Betty’s confidential client information.

In situations such as this, when a third party contacts the attorney on behalf of a prospective or current client, the attorney should inform such person of the attorney’s obligation to hold inviolate the client’s confidences and secrets. The attorney also needs to explain that in addition to his duty to preserve the confidentiality of the client-lawyer communications, he owes his client his undivided loyalty, ensuring against conflicts of interest.46

The ABA Model Rules provide lawyers with discretion to reveal or disclose information in those situations specifically expressed in the black letter of the ABA Model Rules.47 In this illustration, ABA Model Rule 1.6(b)(1) may be applicable insofar as Attorney may conclude that he must divulge confidential client information to Bob “...to prevent reasonably certain death or substantial bodily harm.”48 Comments 14 and 15 to Model Rule 1.6, imposing on Attorney the strong suggestion that diversionary measures be taken before exercising the discretionary exceptions, qualify Attorney’s discretion.49 Based on the qualifications suggested in the comments, Attorney spoke too fast and said too much to Bob, divulging Betty’s confidential information based on the belief that discretionary disclosure would prevent Betty from suffering further financial and emotional abuse at Debbie’s hands. Attorney should have called Betty and explained that Bob was there, asking for her authorization to divulge confidential information and to allow Bob to pay for her further representation in the form of new advance directives.

Additional support for Attorney’s discretionary exercise of disclosure is found in revised ABA Model Rule 1.14 – Client with Diminished Capacity.50 Because Attorney concluded that Betty’s capacity was diminished, he could have disclosed the information to Bob after careful consideration of sections (b) and (c) of ABA Model Rule 1.14. Even under this part of the ABA Model Rules, Attorney must confine his disclosure to Bob to that which would be reasonably necessary to protect Betty’s interests.

IV. CONCLUSION

There is no question that the new wrinkles of diminished capacity will continue to be present, and will escalate in the years to come as the Baby Boomers become seniors. The professional organizations in the many disciplines that serve the elderly must address the ethical dilemmas that confront their members. Elder law attorneys can provide excellent examples of ways in which to address these ethical dilemmas because they practice on the front line of client-lawyer relationships when the clients have diminished capacity. The primary organization that serves this specialty,

47. See ABA 2004 MRPC 1.6, supra n. 23, at 37.
48. Id.
49. Id.
NAELA, has been reaching out to other disciplines, offering to co-sponsor training sessions and symposia by which members of other professional organizations learn how best to serve the new wrinkled faces of capacity. Contact NAELA at www.naela.org. The authors are both past presidents of NAELA.
ATTACHMENT “A”

ASPIRATIONAL STANDARDS FOR THE PRACTICE OF ELDER LAW

Adopted October 28, 2004

By

NATIONAL ACADEMY OF ELDER LAW ATTORNEYS
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PREAMBLE

In the past 20 years, Elder Law has developed as a separate specialty area because of the unique and complex issues faced by older and disabled persons. Elder Law includes helping older or disabled persons and their families with planning for incapacity and long-term care, Medicaid and Medicare, including coverage of nursing home and home care, health and long-term care insurance, and health care decision-making. It also includes the drafting of special needs and other trusts, the selection of long-term care providers, home care and nursing home problem solving, retiree health and income benefits, retirement housing, and fiduciary services or representation. In these and other areas, the Elder Law Attorney is often asked to advocate for clients.
with diminished capacity. Family members and persons with fiduciary responsibilities become involved. The traditional client-attorney relationship is not always clear. Issues such as substituted judgment, best interests, and “who is the client?” present problems not regularly faced by other lawyers.

In recognizing Elder Law as a specialty practice area to meet the legal needs of older and disabled clients and their families, the National Academy of Elder Law Attorneys (NAELA) was founded in 1987. Presently NAELA has more than 4,800 members practicing in all 50 states. In 1994, the American Bar Association accredited the National Elder Law Foundation (NELF) to recognize experienced Elder Law practitioners as Certified Elder Law Attorneys and more than 345 attorneys have now earned the CELA designation. A majority of states have Elder Law Sections or Committees in their State Bar Associations, and 38 states recognize Elder Law as a specialty and a majority of states have Elder Law sections or Committees in their State Bar Associations. Clearly “Elder Law” has come of age.

The following Guidelines set out Aspirational Standards of professionalism and ethical behavior for Elder Law Attorneys. They are the product of study and deliberation by NAELA members and, specifically, NAELA’s Professionalism and Ethics Committee.

Each state’s professional responsibility rules mandate the minimum requirements of conduct for attorneys to maintain their licenses. These Aspirational Standards build upon and supplement those rules. Attorneys who aspire to and meet these Standards will elevate their level of professionalism in the practice of Elder Law and enhance the quality of service to their clients. As attorneys meet these Standards, the practice of Elder Law will be raised to a higher standard of professionalism. These Aspirational Standards do not define or establish a community standard and not intended, and should not be used to support a cause of action, create a presumption of a breach of legal duty, or form a basis for civil liability, professional discipline or disqualification from pending litigation.

A. CLIENT IDENTIFICATION

The Elder Law Attorney:
1. Gathers all information and takes all steps necessary to identify who the client is at the earliest possible stage and communicates that information to the persons immediately involved.
2. Meets with the identified prospective or actual elder client in private at the earliest possible stage so that the client’s capacity and voice can be engaged unencumbered. If the attorney determines that it is clearly not in the best interest of the elder client for the attorney to meet privately with the client, the attorney takes other steps to ensure that the client’s wishes are identified and respected.
3. Utilizes an engagement agreement, letter or other writing(s) that:
   a) identifies the client(s);
   b) describes the scope and objectives of representation;
   c) discloses any relevant foreseeable conflicts among the clients;
d) explains the lawyer’s obligation of confidentiality and confirms that the lawyer will share information and confidences among the joint clients;
e) sets out the fee arrangement (hourly, flat fee, or contingent); and
f) explains when and how the client-lawyer relationship may end.

4. Oversees the execution of documents that directly affect the interests of an individual only after establishing a client-lawyer relationship with the individual.

B. POTENTIAL CONFLICT OF INTEREST

Elder Law Attorneys are frequently approached by families who seek counsel or representation on behalf of one or more persons. Where there is no apparent conflict of interest, joint representation may be a preferred form of representation that will further shared goals, common interests, family harmony, economic efficiency, consistency of action, and enhanced likelihood of serving the best interests of the clients. However, because the potential for conflicts always exists whenever two or more persons are represented, the Elder Law Attorney:

1. In representing multiple family members ensures that the family members understand who are the clients and whether the representation is Joint (i.e., confidences are shared) or Separate. As used in these Standards, separate representation means representing persons in separate matters where confidences are not shared; joint representation (sometimes referred to as common representation) means representation of multiple clients in the same matter.

2. Undertakes joint representation, as permitted by state rules of professional conduct, only after obtaining the consent of the parties after having reviewed with them the advantages and disadvantages of such representation—including the relevant foreseeable conflicts of interest and risks of such representation—in a manner that will be best understood by each person to be represented.

3. Treats family members who are not clients as unrepresented persons but accords them involvement in the client’s representation so long as it is consistent with the client’s wishes and values, and the client consents to the involvement.

4. Accepts payment of client fees by a third party only after determining that payment by the third party will not influence the attorney’s independent professional judgment on behalf of the client, informing the client who consents to the payment by a third party, and ensuring that the parties understand and agree to the ethical ground rules for third party payment (i.e., non-interference by the payer, independence of judgment by the attorney on behalf of the client, and confidentiality).

5. May also serve as a fiduciary for the client, if it is in the client’s best interest and if the client gives informed consent after full disclosure.

6. In representing a client who is a fiduciary under a power of attorney, trust, or conservatorship/guardianship, ensures that the client understands that the duties of both the fiduciary and the attorney ultimately are governed by the known wishes and best interest of the principal.
C. CONFIDENTIALITY

The Elder Law Attorney:
1. Carefully explains the obligation of confidentiality to the client and involved parties as early as possible in the representation to avoid misunderstanding, and to ascertain and respect the client’s wishes regarding the disclosure of confidential information.
2. Establishes as a prerequisite to any joint representation a clear understanding and agreement that the attorney shall keep no client secrets from any other client in that joint representation.
3. Strictly adheres to the obligation of client confidentiality, especially in representation that may involve frequent contacts with family members, care takers, or other involved parties who are not clients.

D. COMPETENT LEGAL REPRESENTATION

The Elder Law Attorney:
1. Recognizes the special range of client needs and professional skills unique to the practice of Elder Law and holds himself or herself out as an Elder Law Attorney only after ensuring his or her professional competence in handling elder law and disability related matters.
2. Approaches client matters in a holistic manner, recognizing that legal representation of clients often is enhanced by the involvement of other professionals, support groups, and aging network resources.
3. Regularly pursues continuing professional education and peer collaboration in Elder Law. Continuing education should include a broad range of Elder Law related subjects as well as an understanding of the physical, cognitive, and psycho-social challenges of aging and disability, and the skills needed to serve persons who are physically or mentally challenged.
4. Ensures adequate training and supervision of legal and non-legal staff with a corresponding emphasis on the knowledge and skills needed to best serve persons facing the challenges of aging and disability.

E. CLIENT CAPACITY

The Elder Law Attorney:
1. Respects the client’s autonomy and right to confidentiality even with the onset of diminished capacity.
2. Develops and utilizes appropriate skills and processes for making and documenting preliminary assessments of client capacity to undertake the specific legal matters at hand.
3. Adapts the interview environment, timing of meetings, communications and decision-making processes to maximize the client’s capacities.
4. Takes appropriate measures to protect the client when the attorney reasonably believes that the client: (1) has diminished capacity, (2) is at risk of substantial physical, financial or other harm unless action is taken, and (3) cannot adequately act in the client’s own interest.
5. When taking appropriate measures to protect the client:
   a) is guided by the wishes and values of the client and the client’s best
      interests;
   b) seeks to minimize the intrusion into the client’s decision-making
      autonomy and maximizes the client’s capacity;
   c) respects the client’s family and social connections; and
   d) considers a range of actions other than court proceedings and adult
      protective services.

6. Discloses client confidences only when essential to taking protective action and
   to the extent necessary to accomplish the intended protective action.

7. Recommends guardianship or conservatorship only when all possible alternatives
   will not work.

8. In representing a fiduciary for a person with diminished capacity:
   a) is guided by the known wishes and best interests of the person with
      diminished capacity; and
   b) in the event a conflict arises between the fiduciary and the person with
      diminished capacity, may disclose otherwise confidential information,
      if necessary to avoid substantial harm to the interests of the person
      with diminished capacity.

F. COMMUNICATION AND ADVOCACY

The Elder Law Attorney:

1. Works to minimize barriers to effective communication with and representation
   of elderly and special needs clients.

2. Maintains direct communication with the client, even when the client chooses to
   involve others in the process, and especially when significant decisions are to be
   made.

3. Advises clients of their options, the practical and legal consequences of each
   option, and the likelihood of success in pursuing each option.

4. Strives to address clients, whether in person, on the telephone, or through
   correspondence, in ways they can readily understand.

5. Advocates within the law courses of action chosen by the client.

6. Provides counsel and representation regarding critical life planning decisions,
   such as long term care planning which may involve repositioning of assets. In
   such cases the Elder Law Attorney should:
   a) strive to ascertain the client’s fundamental values in order to be
      responsive to the goals and objectives of the client;
   b) endeavor to preserve and promote the client’s dignity, self-determination,
      and quality of life in the face of competing interests and difficult
      alternatives;
   c) counsel the client about the full range of long-term care issues, options,
      risks, consequences, and costs relevant to the client’s circumstances;
d) counsel the client regarding asset preservation strategies as appropriate in light of the client’s needs, personal values, and alternatives available; and

e) counsel the client about the estate planning and tax implications of such estate and asset preservation strategies.

G. MARKETING

The Elder Law Attorney:
1. Considers the potential for marketing to educate the public and to promote the profession of Elder Law.
2. Prepares or disseminates only marketing communications that are truthful and do not include statements that are false or misleading in any material respect.
3. Takes into consideration the intended audience for any marketing communication and, in particular, the potential vulnerability of that audience to undue influence.
4. Ensures that no materially false or misleading information is communicated in connection with a seminar, presentation, or similar activity.
5. Has a reasonable basis for any claim that suggests superiority to, or an advantage over, other attorneys.
6. Accurately describes legal concepts, procedures, programs or techniques in all marketing communications.
7. Employs client endorsements only if they reflect the honest opinion or experience of an actual client, and, if the client’s experience is not typical, discloses that fact.
8. Uses organizational endorsements only if those endorsements truthfully reflect the collective judgment of the organization, and discloses any relationship between the organization and the attorney that might materially affect the weight or credibility of the endorsement.
9. Does not engage in uninvited in-person or telephone solicitation of prospective clients who may be vulnerable to undue influence or who may not be able to exercise reasonable, considered judgment in selecting an attorney.

H. ANCILLARY SERVICES

The complex problems faced by elders and persons with special needs involve more than legal issues and services. Some Elder Law Attorneys offer ancillary services such as insurance and annuity sales, care management, tax preparation, and fiduciary or investment services, as allowed by those states that have adopted a rule such as Model Rule 5.7. Clients may find it convenient and reassuring to put their trust in one source to meet a variety of needs.

In the provision of ancillary services the Elder Law Attorney:
1. Is competent and appropriately licensed or credentialed in any ancillary service provided.
2. Ensures that any ancillary services recommended meet the needs of the client.
3. Fully discloses, in writing, all relevant matters to the client receiving ancillary services, including:
a) The terms of the service;
b) Any actual or reasonably foreseeable adverse consequences to the client;
c) Notice that the client may obtain the same services from an independent source, at perhaps a different price;
d) The desirability of seeking independent legal advice;
e) The non-legal nature of the ancillary service and what attorney-client protections apply;
f) The relationship between the attorney and any separate entity; including any financial interest of the attorney in any entity; and
g) The existence of any compensation arrangement for the attorney.

4. Obtains the client’s informed written consent prior to the performance of any ancillary services permitted under the state’s rules of professional conduct.

5. Ensures that all the protections that the client has as part of the client-attorney relationship (such as protecting against financial conflicts and maintaining client confidentiality) remain when the client is also receiving ancillary services or products.

I. PUBLIC SERVICE

The Elder Law Attorney:

1. Recognizes the need for pro bono legal services and meets or exceeds the requirements of Model Rule of Professional Conduct 6.1 (“Voluntary Pro Bono Public Service”).

2. Utilizes the attorney’s special skills and emphasizes service to elders and persons with special needs.

3. Provides ongoing leadership in improving the law to serve the changing needs of elders and disabled persons.
WHO GUARDS THE GUARDIANS? RESTRICTIONS ON COMPENSATING ATTORNEYS WHO SERVE AS GUARDIANS

William J. Brisk, CELA*

Alexis B. Levitt, Esq.**

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I. INTRODUCTION

On September 30, 2004, in the matter of In re Guardianship of Helen Johnson, Massachusetts Judge Rainaud adopted an exhaustive 78 page Master’s Report which approved billing practices of Michael Hooker, an attorney who served as guardian for an incapacitated adult. At the time of the attorney’s appointment, Mrs. Johnson was suffering from severe dementia and residing in a locked area within a nursing home. She died intestate on December 31, 2002, leaving a son, Wallace, as her sole heir. Wallace contested the attorney’s request for compensation as guardian ($9,000) as well as his payments to a real estate attorney retained to quiet title to Mrs. Johnson’s real estate ($5,000), a geriatric care manager ($1,646), a stock broker commission ($814) and fees the attorney had incurred to retain counsel to oppose Wallace’s objections (approximately $10,000).

Wallace contested other aspects of the guardianship including the guardian’s choice of investments, the valuation and sale of real estate and his accounting of expenses. But the real significance of this case is the way the Master, who was affirmed by the court, analyzed the changing rules for determining what an attorney can reasonably charge for services as a fiduciary. While this article focuses on Massachusetts, the general principles and currency of the topic are nationally relevant. This article compares the practices of Massachusetts to those of New York, Florida, and the Uniform Probate Code. The Johnson case illustrates the increasing pressure on attorneys who serve as fiduciaries to justify their expenses, and it reinforces the notion that the lawyer’s success in such controversies depends upon accurate and documented billing and accounting practices.


2. Hereinafter “UPC.” At least sixteen states have adopted the UPC completely or in part. See Legal Information Institute, Uniform Probate Law Locator, www.law.cornell.edu/uniform/probate.html (updated March 2003). The authors also began to analyze conservatorship law in California but learned that while the conservatorship statute allows attorneys to serve as guardians, see Cal. Prob. Code sec. 1811, they very rarely do so because of the prevalence of professional guardians. Tel. Doris Hawks, Esq., July 25, 2005, and tel. Ruth Ratzlaff, Esq., July 25, 2005. As part of their research, the authors called practitioners in the states surveyed, and these conversations are noted throughout the article by “Tel.”
The case explores several issues of great significance for many elder law attorneys. First, will an attorney serving as guardian be permitted to act as the guardian’s (i.e., his or her own) attorney? Second, what is fair compensation for an attorney who serves as a fiduciary, and what is fair compensation for a lawyer who also acts as the guardian’s attorney? Third, what procedural safeguards protect against abuses when attorneys serve as fiduciaries? Fourth, under what circumstances should a fiduciary-attorney consider retaining separate counsel for specific legal functions? Fifth, should an attorney-fiduciary retain a geriatric care manager to maintain direct contact with the ward and the ward’s companions, investment advisors and property managers, and so manage the ward’s assets and care? And, sixth, can fiduciary-attorneys hire counsel, at the cost of the ward’s estate, to defend the fiduciary-attorney’s request for approval of his or her accounts?

II. MAY THE SAME INDIVIDUAL SERVE AS BOTH THE GUARDIAN AND AS THE GUARDIAN’S ATTORNEY?

Massachusetts, Florida and New York, as well as the UPC, allow an attorney to serve as guardian.3 (The UPC uses the term “guardian” to refer to the fiduciary of the person and “conservator” for fiduciary of the estate.4) While in many states guardians may also serve as their own attorneys, they are barred from doing so in others. Massachusetts permits the practice of guardians serving as their own attorneys,5 as does Florida6 and the UPC.7 New York, however, does not.

The New York rule is quite strict: “No. . . guardian shall be appointed as his or her own counsel, and no person associated with a law firm of that. . . guardian shall be appointed as counsel to that . . . guardian, unless there is a compelling reason to do so.”8 Since June 1, 2003, when this rule came into effect, there has been only one case demonstrating a “compelling reason.” In that case, the court approved the fee request of the attorney-guardian for time spent “through substantial efforts” acting as his own attorney in pursuit of reimbursement from his ward’s insurance company for home nursing care.9 The court felt that he had a “compelling reason,. . . namely, his inability

3. See M.G.L. c. 201 § 6; Fla. Stat. § 744.309 (2004); 22 NYCR 36.2(c); Unif. Prob. Code Act § 5-310 and § 5-413 (1998). Interestingly, in Florida, judges are not permitted to serve as guardians except in limited circumstances, such as for family members, and even then, they must serve without compensation. See Fla. Stat. § 744.309(b) (2004). More extremely, in New York, judges and anyone related to a judge “within the sixth degree of relationship” cannot serve as guardian. 22 NYCR 36.2(c)(1).
5. See M.G.L. c. 201 §§ 6 – 13A.
6. “Without obtaining court approval, a . . . guardian of the property . . . may . . . [w]hen reasonably necessary, employ persons, including attorneys, auditors, investment advisers, care managers, or agents, even if they are associated with the guardian, to advise or assist the guardian in the performance of his or her duties” (emphasis added). Fla. Stat. § 744.444(13) (2004).
8. 22 NYCCR 36.2(c)(8).
to find an attorney who would handle the matter on a contingency fee basis due to a perceived unlikelihood of success.”

In the case of Helen Johnson, the Master’s Report not only exonerated the attorney on all grounds, but also actually praised him for delegating key legal responsibilities to other attorneys. Specifically, the Master approved of the attorney outsourcing the task of curing title to the ward’s real estate even though the property had very little value because of its decrepit condition, location and general real estate conditions. The Master concluded that: (1) the rates charged by outside counsel “were consistent with rates charged in Franklin and Hampshire counties for litigation services, and were reasonable” and (2) the scope and quality of services provided by [the other attorneys] were consistent with, and responsive to, the legal needs of the ward.

The result in Johnson appears reasonable, and attorney-fiduciaries are well advised to delegate specific tasks requiring specialized knowledge. However, the Master’s Report and general literature ignore a persistent question: What are the precise standards for outsourcing or not outsourcing litigation or other legal tasks, or for providing such services?

III. WHAT NON-LEGAL TASKS SHOULD LAWYER-FIDUCIARIES DELEGATE?

Attorney-guardians sometimes delegate non-legal tasks to save time, serve higher-paying clients, and better serve the ward. For example, the attorney-guardian may hire another professional, such as a geriatric care manager or accountant, to handle some of the non-legal tasks of the guardianship. New York’s statute is silent on whether this is permitted, but the other states and the UPC allow it, apparently encouraging guardians to hire the best person for the job as well as recognizing that a guardian’s time is sometimes better spent on other tasks.

A. Massachusetts

In the Johnson case, the Master approved of the attorney’s decision to delegate many of the most time-consuming tasks to a qualified geriatric care manager, who visited regularly with the ward, updated herself on the ward’s condition, attended status conferences, and ran errands for the ward. The Master noted that:

- Hiring a geriatric care manager (GCM) provided qualified and needed skills that most attorneys do not have.
- Rates charged by GCMs (and presumably other professionals) were “consistent with the needs of the ward and responded commensurately to those needs.”

Moreover, the Master observed that had the GCM not performed her services, “they would have had to have been performed by someone else, at a similar or higher

10. Ress at 1.
12. Id.
rate” and that having a GCM perform certain services “allowed Mr. Hooker to concentrate on other aspects of the ward’s affairs, where his time was better spent.”

The Master also approved the payment of a small broker’s commission to sell stock, overcoming the son’s argument that the attorney could have saved the estate a small commission if he had invested in no-load mutual funds not subject to any direct commissions. By choosing an investment advisor, however, even for a relatively small estate, the attorney relied on an expert rather than on his knowledge and experience, and so insulated the investment decisions from criticism.

B. The Other States

New York’s guardianship statute states that the guardian shall exercise only those powers the Guardian is authorized to perform by the Court. New York law allows the Court to grant powers that it deems are necessary including the power to determine who shall provide personal care or assistance to the alleged incapacitated person. Implicit in this power is the ability to delegate the actual provision of those services to appropriate parties. However, does this statute allow the Guardian to delegate that decision-making to another, such as a geriatric care manager? In matters which appear to warrant this manner of delegation and/or counsel, it is good practice to incorporate this right of delegation into the Order. Later, if the guardian wishes to delegate any other functions, the best practice is to seek the court’s prior approval. Doing so reduces the prospect that payment for the delegated services will be denied on review of the annual account. New York also provides the Court with guidance as to the permitted delegatory powers of a proposed Guardian. The New York statute sets forth a list of potential powers including, the right to retain an accountant, as well as the ability to invest funds of the incapacitated person pursuant to the provisions of the NY EPTL (Estates, Powers and Trusts Law) 11-2.3. It is notable that 11-2.3 specifically authorizes the fiduciary to employ such investment professionals as are appropriate.

Florida, as noted above, encourages the guardian to delegate non-legal functions by permitting a guardian to “employ persons. . . to advise or assist the guardian in the performance of his or her duties.” The UPC explicitly permits a conservator to delegate tasks but is silent on whether a guardian may do the same.

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14. Id. at 15-16.
15. See Ment. Hyg. Law § 81.22, which describes powers of a guardian regarding the ward’s personal needs and is silent on whether the guardian may delegate any of these.
17. Tel. Howard Krooks, July 22, 2005. (Check with Howie, the statement previously attributed to me was not completely accurate, make sure he is good with this before printing)
IV. CAN ATTORNEYS CHARGE THEIR USUAL RATES FOR RENDERING FIDUCIARY SERVICES?

In those states permitting guardians to act as their own attorneys, the question that arises is whether attorney-fiduciaries can charge their attorney rate while performing a fiduciary’s functions, or, must they charge differentiated rates that depend upon whether they are performing legal functions or functions that could be performed by non-lawyers who would charge less?

A. Massachusetts

Over the past two decades in Massachusetts, there has been a trend against allowing attorneys to charge double for their activities when they serve simultaneously as attorneys and fiduciaries. The statute regarding compensation of fiduciaries lists the usual factors that determine reasonable compensation for fiduciaries: size of the estate, time reasonably required for completing work, amounts usually paid to others for similar work, etc. Fiduciaries are advised not to base their compensation on flat fees or as a percentage of a ward’s estate, but rather on work actually performed.

1. In re: Guardianship of Helen Johnson

As guardian, the attorney charged $150 per hour for services ranging from the preparation and presentation of pleadings to the court through meeting with the geriatric care manager, managing the ward’s accounts, conferring with her relatives and consulting with a contractor about dilapidated real estate that the ward owned. The Master determined that:

- The rates charged for such services were “consistent with rates charged in Franklin and Hampshire counties for such services and were reasonable.”
- The attorney’s activities “were responsive to the continuing needs of the ward and reasonably calculated to meet those needs.”

Note that not all of the work for which the attorney billed required a lawyer, so an unresolved question in this case is whether and at what rate a lawyer can charge for performing non-legal work. The distinction between “legal” and “non-legal” work is not clear. Most visits to the ward could be construed as “legal.” The attorney has a duty to maintain contact with his client, to assess his or her physical condition and state of mind and even to involve a demented ward in decisions to the extent possible. Is a lawyer-fiduciary, then, entitled to bill at an attorney’s rate for negotiating the sale of real estate?

21. See Master’s Report, supra n. 1 at 11-12.
26. Master’s Report, supra n. 1 at 11-12.
27. Id.
of property (as opposed to negotiations directly related to closing on the real estate), opening and closing bank accounts, making deposits, writing checks, purchasing items for the ward, attending "status meetings" with health care providers, and other activities that do not require a lawyer to perform? While an activity as simple as creating a special bank account for the Guardianship does not require a law degree, the attorney needs to be present to open the bank account and that represents time that could otherwise be expended on other, paying clients. Further, if a lay guardian charges $30 an hour for opening a bank account, is it appropriate for a lawyer to charge $200 for the same activity? It could be argued that in going to the bank and personally signing papers, etc., the lawyer is taking time off from pursuits that are more remunerative.28 Still, normally compensation is based on the value of the services performed rather than on the value of the time of the person who performed the services. Perhaps blessedly, case law does not seem to be heavily weighted with too many distinctions between what is "legal" and "non-legal," leaving considerable room for advocacy. The courts appear to allow for some flexibility in determining the character of such work.

2. Ethical Rules

Ethical standards that help determine reasonable attorney's fees are found in Rule 1.5 of the Model Rules of Professional Conduct (MRPC). Massachusetts' particular version of Rule 1.5 takes a less punitive position than found in ABA Model Rule 1.5. The Massachusetts rule states that to discipline an attorney for violating the rule on fees, the "fee must be illegal or clearly excessive,"29 whereas the ABA rule prohibits a lawyer from charging a fee that is "unreasonable."30

A fiduciary-attorney, however, should not rely on MRPC 1.5 for full guidance, because MRPC 1.5 implicitly assumes that a competent client reached a fair agreement with the attorney. Comment 1 to Rule 1.5 strongly recommends, but does not require, a written agreement, but such a recommendation is meaningless when the attorney serves as fiduciary for an incompetent individual who cannot contract for services. Even if there is no contract, it might be useful for the attorney-fiduciary to prepare for the file a statement adapted from the attorney's standard Retainer Agreement to guide future billings. Such a statement, although not rising to the level of an enforceable contract, is analogous to a Declaration of Trust by a Grantor-Trustee, establishing rules that will govern his or her management of a trust holding assets that previously belonged to the Trustee.

While Rule 1.5 does not explicitly condemn flat fee billing in general, Massachusetts probate judges have signaled their general distaste for guardians to

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28. Perhaps the larger fee can be justified under one of the explicit factors for determining whether a fee is clearly excessive. Model Rules of Professional Conduct (hereinafter MRPC) Rule 1.5(e) (2004): "the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer."


30. ABA Model R. Prof. Conduct 1.5(a) (2004).
employ such arrangements. Consequently, the lawyer must be prepared to justify his or her fee by accounting for the hours spent on serving the ward. Further, the lawyer cannot base his or her fee on the wealth of the ward.

Echoing this principle, and explicitly balancing the attorney’s right to earn a living with protecting the ward from an overreaching fiduciary, Judge Sacks disputed a common misperception: “it is not proper that there be a formalized expectation that what is lost in one case, fee-wise, will be made up in another asset case, nor that the time to ‘make up’ is when the money is ‘just going to the Commonwealth.’”

While there might be some justice in allowing liberal fees to an attorney who donates time to cases which pay little or nothing, a judge ruling on what is fair in a particular case may not enjoy the emotional luxury of “balancing the equities” for different wards. While Judge Sacks recognized that the court must be concerned about making “serving as a guardian more attractive given the unavailability of individuals to serve as guardians,” he denounced efforts to even up compensation by assigning attorneys to a mix of lucrative and non-lucrative cases. The issue also arises when Massachusetts probate courts appoint attorneys as Guardians Ad Litem, counsel to wards, and Masters, relying on “lists” based on actual credentials and commitments to relevant continuing legal education programs.

3. General Standards for Attorney Compensation

The general standard used to determine appropriate legal fees, the “Lodestar,” is classically expressed in *Brewster v. Dukakis* in which the court exhaustively reviewed the bills of about twenty public-interest lawyers who had sued the state to deinstitutionalize patients in state hospitals. Ultimately, as translated by Judge David Sacks in *Verteville*, the court distinguishes three levels at which an attorney may be appropriately compensated according to how significant his or her qualifications as a lawyer are to performing different functions:

1. The normal and usual fees paid to a lay guardian for those functions which could be performed equally well by a lay guardian;
2. The fees in the 50-67 percentile range of the legal fees the attorney ordinarily charges for functions which a lay guardian could handle, but would be more efficiently managed by an attorney-guardian; and
3. The full legal fees for functions for which the lay guardian would need the services of an attorney, but without double billing as attorney and guardian for the same hours.

A Massachusetts attorney was publicly reprimanded for over-billing for fiduciary services at his legal billing rates when “most” of the activities he performed did not require a lawyer’s credentials or knowledge. Attorney Kliger served as a mother’s

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32. *In re: Lillian Verteville*, Probate Court, Hamden Division (Massachusetts), No. 97P1616-G1 (1999).
unofficial caretaker and later as conservator and then co-administrator of her estate with her daughter. In settling the estate, Kliger paid himself $90,000 for serving in the three capacities: co-administrator, attorney for client, and as unofficial caretaker between February 1992 and July 1995. The Board of Bar Overseers\(^{35}\) Report states that “Most of the services performed for the client were non-legal...” (emphasis added) and Kliger “improperly billed the client at his regular legal rate of $200 per hour.”\(^{36}\) Later, when the court was presented with a petition to name a guardian for the daughter, it appointed counsel for the daughter who, in turn, filed an equity complaint against Kliger seeking to compel Kliger to return the fees he had paid himself from the mother’s estate. Kliger settled out-of-court with the daughter and returned $60,000 to the guardianship account. The Board of Bar Overseers publicly reprimanded Kliger for what he had done.\(^{37}\)

Despite its brevity, the memorandum in *In re: Kliger* poses a number of significant principles:

- **Record-Keeping.** As in other similar cases, the attorney was guilty of poor record-keeping that often goes hand in hand with “unofficial” or “informal” care. Indeed, as an axiom, it can probably be stated that the worse the records, the more severe the punishment. In contrast, good records often earn more leniencies from the court and Board of Bar Overseers.

- **Non-legal work.** Kliger was accused of charging at his usual legal rate for non-legal activities, which constituted “most” of what he did. This leads us to ponder whether if the non-legal work Kliger performed had been a smaller portion of what he did, would he have escaped discipline? In other words, is there a certain safe harbor, a quantum of non-legal work for which one might bill at one’s customary rate for legal services, and so long as one does not exceed that quantum, complainants will not be entitled to return of fees? The answer is probably no. The wise lawyer will carefully segregate and account for legal and non-legal work and only bill his or her customary hourly rate for the legal work.

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35. The Board of Bar Overseers is the governing body for lawyers in Massachusetts.


37. A more serious punishment befell a Wisconsin attorney who billed her ward, who lived alone in the community with manifest psychiatric issues, more than $150,000 for services spanning almost three years. A lengthy opinion barred the attorney-fiduciary from practicing law for a year largely because she had billed at her rate as a lawyer for what were primarily non-legal services. While the punishment was severe, especially since the ethics opinion ignored the difficulty of serving such a client (most attorneys who have dealt with disturbed clients know that whatever compensation is received hardly makes such cases worthwhile), the respondent in that case should have taken time to build a network for specific skills and services that her ward required. Failing to do so not only increases billing, it also means that the ward might not obtain seasoned and specialized assistance. The overriding lesson in this case is delegate. *In the Matter of Disciplinary Proceedings Against Jill S. Gilbert*, Wisconsin Supreme Court No. 95-3561 (2002).
In the early stages of a guardianship, a considerable amount of work of a non-legal nature must be performed. The typical guardian, whether a lawyer or not, performs a number of mundane, but important, functions that do not require legal expertise, such as picking up laundry, dealing with relatives and friends who are suddenly concerned about the ward, deciding whether to break a lease for someone who is likely to remain institutionalized, establishing ground rules for medical care, inspecting prospective housing for the ward, and even checking the ward’s refrigerator. During the initial stages of a guardianship there may be compelling reasons for an attorney to perform these functions because some of the functions are so time-sensitive that delaying to delegate (which requires contacting that person, instructing the person as to what needs to be done, and, in many cases, providing authorizations to the person) may not be in the best interests of the ward or the estate. Moreover, performing some of these functions may be instructive for the newly appointed guardian. If the lawyer is permitted to charge his or her hourly rate when acting as guardian, there seems no reason for a court to not permit that rate for these quotidian, but critical, tasks.

B. Florida

Because Florida relies on professional guardians, attorneys do not often serve as guardians.\(^{38}\) When they do, however, the rule on compensation in Florida is similar to that of Massachusetts. Attorney-guardians may bill at different rates for their legal work and for their non-legal work. There is no mandated billing rate for either type of work. Instead, the court applies a “criteria test” to both, considering, for example, the time and labor required, the novelty and difficulty of the issues involved and the skill required to perform the services properly, the likelihood that the acceptance of the particular employment will preclude other employment of the person, the fee customarily charged in the locality for similar services, and the experience, reputation, diligence, and ability of the person performing the service.\(^{39}\)

When an attorney-guardian does present a bill for both types of services, the court “must clearly distinguish between fees and expenses for legal services and fees and expenses for guardian services and must have determined that no conflict of interest exists.”\(^{40}\) While there are no clear guidelines as to what fees an attorney-guardian may charge, a cue may be taken from professional guardians who earn $30 to $90 an hour, and from attorneys of guardians who generally charge $195 to $250 per hour.\(^{41}\)

C. New York

In New York, compensation to a guardian, whether an attorney or not, is determined on a case-by-case basis. “The court shall establish, and may from time to


time modify, a plan for the reasonable compensation of the guardian." 42 The compensation plan “must take into account the specific authority of the guardian to provide for the personal needs and/or property management for the incapacitated person.” 43 In one case the court allowed an attorney-guardian to collect $100 per hour for his time as guardian in the years 1993 to 1997, but the court indicated that his was an exceptionally difficult case, given the ward’s complicated health care and the harassment suffered by the guardian from the ward’s family. 44 Each judge considers the value of the ward’s assets as a critical component of the basis for the fee. 45 Some courts grant compensation to the guardian on a commission basis, i.e., as a percentage of the value of the estate, where the guardian’s tasks are largely financial management. 46 As can be expected where fees are set case-by-case, there is a great variation in acceptable fee schedules among judges, counties, and regions of the state. 47

While guardians in New York rarely serve as their own attorney, New York seems to recognize that when they do serve in dual roles, they are entitled to charge a higher rate for their legal work. The statute governing guardianships is silent on this issue, but in Arnold "O" (1998), the court allowed legal fees of $125 per hour to the guardian for legal work performed by himself and his firm, although the court allowed payment for only two-thirds of the legal hours requested by the attorney-guardian. 48

D. Uniform Probate Code

The UPC states that guardians, conservators, and lawyers are all entitled to “reasonable compensation.” 49 There is no provision dealing especially with attorney-guardians or attorney-conservators.

V. SPECIAL PROCEDURES FOR ATTORNEY-FIDUCIARIES TO OBTAIN APPROVAL OF FEES

To protect the ward’s finances, all three states surveyed and the UPC require an initial inventory and accounting followed by annual accountings. 50 The UPC, Florida, and New York also call for annual in-depth reports indicating the care the ward has received, an update on her living conditions, the plan for future care, and whether the ward still qualifies for a guardianship. 51 In Florida and New York, the guardian or the lawyer, including the attorney acting as guardian, can present his or her fee to the court

42. Ment. Hғ. Law Sec. 81.28(a).
43. Id.
46. See Ment. Hғ. Law Sec. 81.28; Arnold "O", supra n. 45 at 630.
48. Arnold "O", supra n. 44 at 629.
for approval as part of the annual accountings or more frequently. In Massachusetts, a lay guardian can make payments to herself or any other service-provider without court order. Under the UPC, a conservator can do the same. Massachusetts is the only state of those surveyed with special requirements for fee approval where the guardian is also an attorney.

A. Massachusetts

Certain persons in court-appointed, fee-generating positions cannot receive payment for their services until they have filed an itemized fee request with the court and, where applicable, have obtained court approval. These include a Guardian ad Litem, a commissioner to sell real estate, a special master, any guardian who was not named in the petition initiating the guardianship proceedings, and any attorney or social worker serving as guardian (but not including non-attorney and non-social worker guardians who were named in the petition). The apparent rationale is that, in the absence of an actual contract between the ward and attorney, unscrupulous fiduciaries could take advantage of unknowing wards by using their general authority to pay bills to enrich themselves by paying inflated fees. Although they cannot pay themselves directly, Supreme Judicial Court (hereinafter SJC) Rule 1:07 also covers Masters and Guardians ad Litem, perhaps because even if they do not control the purse strings of the ward, they enjoy considerable leverage over the parties who do.

While SJC Rule 1:07 demands court approval of fee requests, the rule is ambiguous about how such a fiduciary must proceed. In four counties in Eastern

53. See Unif. Prob. Code Act § 5-417 (1998). If there is a separate guardian of the person, the conservator can make payments to her without court approval. However, where there is only a guardian, she must seek a court order allowing her fees. Again, these rules apply whether or not the fiduciary is an attorney. See Unif. Prob. Code Act § 5-316(a) (1998).
54. See generally discussion following.
55. SJC Rule 1:07 reads: “(7) Payments. No payment shall be made or received on account of any appointment required to be recorded in the appointment docket until a statement under the penalties of perjury, certifying the services provided, amount of payment, and itemization of expenses, is filed with the clerk, register, or recorder, to be placed with the papers in the case. No person holding an appointment required to be recorded in the appointment docket under section (5) of this rule shall make any payment to himself or herself until such payment is approved by the court.” Section 5 lists various fee-generating court appointments such as Guardians ad Litem, court appointed investigators, real estate appraisers, commissioners appointed to sell real estate, appellate court conference counsel, masters and special masters, counsel for a ward, monitors for the administration of antipsychotic medications, investigators in care and protection of minors proceedings, and even title examiners, and, important to this article, persons appointed as “administrator, trustee, guardian, conservator, or receiver whose appointment was not prayed for by name in a petition, pleading, or written motion and any guardian or conservator who is an attorney, social worker or other social service professional unrelated to the ward…” (emphasis added).
56. In order to avoid this rule, which can be quite stringent and costly to the ward’s estate, it may be useful to make certain that any such appointment results from or even is confirmed by a Motion filed with the court and heard.
Massachusetts, Probate procedures vary significantly. In Middlesex County, which comprises Cambridge and a number of towns North and West of Boston, apparently one only needs to file an accounting. The usual procedure is to file an accounting that includes prospective compensation that might actually be paid into the attorney’s clients’ funds account, but not into his or her business account. Payment out of the clients’ funds account should not be made until the court allows the account – and that can be almost immediate (if the attorney presents “consents” from all interested parties), forty-five to sixty days if the court issues a citation to notify all interested parties, or can take months or years if one of the interested parties files an objection. In Boston (Suffolk County), the attorney must file a Motion with a bill appended. It is implicit that no payment can be made until the court disposes favorably of the Motion. Presumably, interested parties are entitled to notice, but without the formalities of a Citation, which often would require publication as well. Norfolk County’s Probate Court (which comprises the cities of Brookline and Quincy and a number of well-to-do suburbs) facilitates the process by allowing an attorney-fiduciary to fax to an assistant register a Rule 1:07 Statement, which will be presented to a judge. On the other extreme, Plymouth County (which comprises towns in what is called the “South Shore” of Boston) the court requires that an attorney-fiduciary file a General Petition (which costs $150 for filing) and go to the expense of serving all interested parties according to a citation the court will issue (which may require the additional cost of publishing a notice in a local newspaper).

The variations among the procedures are quite striking and suggest that there are many opinions on the best way to protect the financial interests of mentally compromised wards and clients. While the more stringent requirements may deter abuses, they add to the total cost of such appointments and are ultimately paid for out of the ward’s funds.

B. Florida

The same procedural requirements for fee payment apply to attorney-guardians as apply to all guardians and to all guardians’ attorneys. The court must approve fees, and all petitions for guardian’s fees and attorney’s fees must include an itemized description of the services performed with prior notice to the guardian and the ward.

C. New York

The statute has no provision specifically addressing payment to an attorney-guardian. The statute indicates, “[t]he court shall establish, and may from time to time modify, a plan for the reasonable compensation of the guardian.” Typically, the fiduciary waits for payment until his request for fees has been approved as part of the

57. The authors phoned the Registers’ Offices in Middlesex, Suffolk, Norfolk, and Plymouth county Probate and Family Courts.
annual report. Some guardians choose to make interim requests to the court for approval of fees, particularly if the guardian is putting in substantial time on the case.60

D. Uniform Probate Code

Similar to the law of New York and Florida, the UPC has no special procedure that an attorney acting as conservator must follow when seeking payment for his or her fees. The conservator follows the same process as any other conservator or attorney. As described above, the conservator can pay compensation at any time without court order,61 accounting for it in the annual report.62

In sum, Massachusetts is the only jurisdiction of the ones surveyed with a special provision for fee approval when an attorney serves as guardian.

VI. IF THE LAWYER-FIDUCIARY’S ACCOUNTS ARE CHALLENGED, THE ESTATE’S FUNDS MAY BE AVAILABLE TO HIRE AN ATTORNEY TO DEFEND THE ACCOUNTS

A risk that any guardian faces is that his or her accounts may be challenged. Even if exonerated, the guardian needs to recover the costs of the defense. Florida specifically permits recovery from the ward’s assets. The statute reads:

When court proceedings are instituted to review or determine a guardian’s or an attorney’s fees . . . such proceedings are part of the guardianship administration process and the costs, including fees for the guardian’s attorney, shall be determined by the court and paid from the assets of the guardianship estate unless the court finds the requested compensation. . . to be substantially unreasonable.63

In New York,64 Massachusetts, and under the UPC,65 the question is resolved on a case-by-case basis, with the trial judge deciding on a fair and just outcome.

The Johnson case required the attorney to justify virtually every aspect of his guardianship, particularly payments totaling about $40,000 that he made to himself and others. The attorney briefly considered whether to ask his malpractice carrier to defend him and cover the cost of any settlement or judgment. He decided not to do so because he was not certain that the rider on his policy, which referred to claims against his actions as a fiduciary, would trigger the policy for a claim based on excessive compensation. Moreover, even if the carrier covered the claim, he was concerned that reporting this and other such claims (regardless of how frivolous) would result in either inflated premiums or dropped coverage.

64. Tel. Howard Krooks, July 22, 2005.
Instead, he retained his own attorney. After the attorney prevailed, the Master allowed the payment of the attorney-fiduciary’s fees in defending his accountings on several grounds: (1) the guardian would be a necessary witness in the litigation, (2) the objections were petty and insignificant and intended to harass, and (3) “dealing with the mounting number and complexity of the objections himself would have distracted Mr. Hooker from otherwise attending to the needs of the ward.”

The Master applied two tests. The first, M.G.L. c. 215 §45, allows payment from the ward’s estate “as justice and equity may require.” In most cases, this cannot be determined until the attorney is cleared from wrongdoing. The second test requires the trier of fact to determine that the litigation attorney’s bills were fair and reasonable or, in the terms used by the Master, were “well and at a fair rate.”

In sum, lawyers who serve as fiduciaries of solvent estates in Massachusetts are entitled to reasonable compensation. They are entitled to compensation at their regular rates for carefully documented and itemized work that most efficiently can be done by a lawyer. They should delegate work to specialists (lawyers and non-lawyers) who can perform more efficiently than the fiduciary. The single most significant factor in litigated cases seems to be whether the attorney-fiduciary kept good contemporary records of all activities undertaken.

When asked what he learned from his ordeal, Attorney Hooker responded:

1. Be sure that interested parties receive actual notice. The attorney was not involved with the original petition for guardianship but was appointed from a court’s list of appropriate attorneys. Upon receiving the petition, he noted that actual service on the ward’s son had not been made, and he soon discovered that the address for the son in the petition was outdated. He wisely retained a service to locate the son. He concluded that, as painful as the experience was after the son learned of his mother’s plight, failure to give him actual notice might have prolonged the agony even more.

2. Obtain court approval of your fee schedule at the outset of your appointment.

3. Get professional appraisals for all assets.

4. Hire a property manager even for a “vacant” property and pay enhanced premiums to maintain insurance on such property.

5. File accountings early (but do not necessarily seek allowance, especially if an inappropriate GAL might oppose it, because a different GAL may be appointed after the ward dies, or there may be none at all).

6. Consider reserving funds in a client’s funds account (an escrow account) to pay for anticipated costs, fees, and other expenses, which have not yet been approved, although some question whether the guardian has authority to distribute from a client’s sub account after the death of the ward.

66. Master’s Report, supra n. 1 at 42-43, 68.

67. Id.
VII. CONCLUSION

This survey of three states and the UPC reveals the tension that arises when an attorney acts as guardian. This tension arises from an attempt to balance between protecting wards from unscrupulous, or perhaps unknowing, attorneys on the one hand, and respect for a self-governing profession on the other. It also highlights several common themes, including that a guardian who acts as his or her own attorney should charge differentiated fees based on the tasks performed and that the guardian should delegate tasks that can be performed more efficiently by others. Fundamental financial questions, such as hourly rates and whether a fiduciary might recover the costs of defending his or her accounts are often decided on a case-by-case basis. The responses, particularly as to fees, can vary by region, county, and even adjudicator. While this may allow for an appropriate response tailored to each case, the uncertainty can be very frustrating for fiduciaries.
THE IMPACT OF THE UNIFORM TRUST CODE ON SPECIAL NEEDS TRUSTS

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Both authors are members of NAELA, are Fellows of the American College of Trust & Estate Counsel, have worked with the National Uniform Trust Code Committee on issues regarding creditor rights and SNTs, spoke at NCCUSL’s first annual National UTC Conference in 2005 on the topic of this paper and will speak on this topic at the 2006 ACTEC annual meeting, and their materials on this topic have been published in Estate Planning, Trusts & Estates, Probate Law Journal of Ohio, and elsewhere.
I. INTRODUCTION

During the last year, some practitioners have raised concerns that the Uniform Trust Code ("UTC") will negatively affect Special Needs Trusts ("SNTs"). This paper provides an in-depth analysis of the issues that are involved in this debate. This paper also demonstrates conclusively that the UTC poses no threat either to self-settled or to third party-settled SNTs. Article 5 of the UTC "Creditor's Claims; Spendthrift and Discretionary Trusts," as well as Section 814, "Discretionary Powers; Tax Savings" raises the primary areas of concern as they relate to SNTs. The issues fall into three main areas of concern:

1) Will the UTC allow governmental entities that provide benefits to an SNT beneficiary to reach the trust assets or attach trust distributions?
2) Will SNTs be countable resources, thereby causing the beneficiary to lose eligibility for public benefits to which the beneficiary would have otherwise been entitled, because of UTC?
3) Will the UTC provide the general creditors of an SNT beneficiary increased ability to reach trust assets or to attach trust distributions?

The answer to all three questions is "NO!"


2. For purposes of this outline, “special needs trusts” and “supplemental needs trusts” are generically combined under the term “special needs trusts” (SNTs).
II. GOVERNMENTAL PROVIDERS OF PUBLIC BENEFITS AS CREDITORS

A. Governmental entities that pay out public benefits to disabled individuals generally are not creditors.

Individuals who meet the federal definition of being “disabled” may be entitled to receive either Social Security Disability Income (“SSD”) or Supplemental Security Income (“SSI”). SSD and SSI both consist solely of federal funds, so there is no possibility of the State becoming a creditor with respect to these benefits. There is no federal payback requirement for either SSD or SSI, except for benefits improperly paid. Disabled individuals who qualify for SSD generally also receive Medicare coverage for their health care needs. As is the case with SSD, Medicare generally has no payback requirements.

Disabled individuals who qualify for SSI are usually eligible for Medicaid benefits as well. The States, but not the federal government, are creditors with respect to certain Medicaid benefits paid to certain Medicaid recipients, as set forth below, but generally not until after the death of the recipient.

4. The law governing SSD is found in Title II of the Social Security Act, 42 U.S.C. § 401 (2005) et seq. SSD is part of a larger program more fully known as The Old Age Survivors and Disability Insurance (OASDI).
5. There is a great deal of confusion between SSD and SSI. Many disabled individuals who receive these benefits are not aware of which one they are receiving, as both are administered by the Social Security Administration. SSD is not means tested, while SSI has strict income and resource limits. SSI and SSD use the same “disability” definition.
6. TEFRA (Pub. L. 97-248, specifically Title I, § 96 Stat. 370) enacted, and OBRA 1993 (Pub.L. 103-66) modified, what is referred to as the Medicare Secondary Payer (MSP) statute, which is contained in § 1862(b) of the Social Security Act, 42 U.S.C. § 1395y(b) (2005). Regulations are in 42 C.F.R. Part 411. Under MSP, there is a Medicare Coordination of Benefits (COB) program. A Medicare COB Coordinator must be contacted whenever medical services have been rendered to a Medicare recipient that may be related to a Workers Compensation claim or to a personal injury lawsuit, where another payer may have primary liability for the payment of medical expenses. If, however, an SNT were established for a beneficiary covered by Medicare and funded with proceeds from a personal injury settlement, Medicare would have a lien against the SNT if the COB procedures mandated by the MSP statute were not followed. The CMS web page regarding COB is located at http://www.cms.hhs.gov/medicare/cob/factsheets/fs_attorneys_msplaws.asp.
7. In providing Medicaid to individuals who are receiving or deemed to be receiving SSI, states fall into one of three categories. Thirty-two states, referred to as “§ 1634(a) States,” have a contract with SSA to determine eligibility for Medicaid as part of the same process used to determine SSI eligibility. These States (and the District of Columbia) also use the same Medicaid eligibility criteria for categorically needy (i.e. blind, disabled, or aged) Medicaid that SSA uses for the SSI program. Seven other states, called “SSI-Criteria States,” use the same Medicaid eligibility criteria used by SSA for SSI determinations, but require these individuals apply to the State separately for Medicaid coverage. The remaining eleven states, the “§ 209(b) States,” use more restrictive Medicaid eligibility criteria than the criteria used in the SSI program.
B. Federal law mandates Medicaid estate recovery.

The States are required to seek to recover certain Medicaid benefits following the death of the institutionalized recipients and recipients who were over the age of fifty-five. The federal statutes under which States have reimbursement rights with respect to these Medicaid benefits are set forth in Appendix B. The federal government has no right to seek the return of Medicaid benefits; however, the States must share with the federal government a portion of all amounts recovered.

Federal law expressly prohibits States from seeking recovery during the lifetime of the Medicaid recipient, and even after death, federal law contains important safeguards for surviving spouses and certain other individuals. During the lifetime of the Medicaid recipient, the State is not a creditor, except to the extent that the State may have enacted legislation and amended its State plan to permit the use of Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) liens against the residence of certain permanently institutionalized Medicaid recipients.

A State, by passing enabling legislation and by amending its State Plan with the Centers for Medicare & Medicaid Services (“CMS,”) may file a lien against the real estate of a “permanently institutionalized” Medicaid recipient during the recipient’s lifetime under certain limited circumstances. TEFRA liens attach only to the property interests of the Medicaid recipient. Therefore, if the Medicaid recipient owned an undivided one-half interest in real property, the lien could only attach to the recipient’s one-half interest. Real property that a third party settled SNT might own (such as the home in which the beneficiary was residing prior to institutionalization) would not be real property “of” the beneficiary, but, rather, would be property “of” the trust. Moreover, the interest would not be subject to lien under state law, as legal title is vested in the trustee. Unlike the federally mandated OBRA estate recovery, which allows the States flexibility in defining the extent of the “recovery estate,” TEFRA provides for no such flexibility.

After the death of a Medicaid recipient, the State must seek to recover certain amounts paid for medical assistance from the “recovery estate.” Federal law requires that the “recovery estate” (i.e. the “estate” against which recovery may be sought) consist of “all real and personal property and other assets included within the individual’s estate, as defined for purposes of State probate law.” States, by enacting enabling legislation, may expand the definition of the recovery estate to include:

- any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased

9. Because each state has certain rights following the death of the Medicaid recipient, before death the state may be a “future creditor” under fraudulent conveyance statutes.
10. See Appendix B for a discussion of TEFRA liens.
11. See Appendix B.
individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.\textsuperscript{12}

Estate recovery rights hinge on two factors, (i) the State’s definition of the “recovery estate,” (which is not a UTC issue) and (ii) the nature of the Medicaid recipient’s interest in the property against which recovery is sought. If, and only to the extent that, the UTC creates in the SNT beneficiary a new or expanded right to compel distributions (which right the beneficiary lacked under prior law), would the UTC enhance the State’s recovery rights. The UTC, however, neither creates such a right nor expands any rights that may exist under common law principles.\textsuperscript{13}

May a state define the “recovery estate” broadly enough to enable it to recover against assets of an SNT following the death of its beneficiary? The issue is moot with respect to self-settled SNTs, since they are required to include a mandatory Medicaid payback provision. Regarding third party SNTs, the beneficiary has no “legal title” in the assets of the SNT, but probably does have an “other interest” in the trust assets.\textsuperscript{14} Recovery, however, can only be made “to the extent of such [i.e. the beneficiary’s] interest”. Because the beneficiary’s interest is generally subject to the trustee’s discretion, with no support standard, recovery should not be available. This is very similar to the inability of the federal government to enforce a federal tax lien against the interest of a beneficiary in a discretionary trust that lacks a distribution standard. Generally, where a trust gives the trustee uncontrolled discretion over distributions, the beneficiary does not have an interest that is subject to a federal tax lien; however, distributions made to the beneficiary are subject to attachment.\textsuperscript{15} The same analysis should apply in the estate recovery context.\textsuperscript{16}

\textbf{C. Spendthrift Protection against Governmental Entities}

Concerns have been expressed that future changes to federal and/or State law may expand the rights of the federal or state governments to seek repayment of governmental benefits, and that the UTC’s recognition of the “exception creditor” status of federal and state governments will make it easier for them to recover from SNTs benefits that they have paid.

Just as the federal government is unable to reach assets held in a pure discretionary trust, so would attempts by a state to reach assets held in a discretionary

\textsuperscript{13} See the discussion under II entitled “When can a beneficiary compel a distribution.”
\textsuperscript{14} In re Marriage of Jones, 812 P2d. 1152 (Colo. 1991) (recognizing that the beneficiary of a discretionary trust has an equitable interest in the subject matter of the trust, citing 2 Austin W. Scott and William F. Fratcher, The Law of Trusts § 130 (4th ed. 1987).
\textsuperscript{15} 2A Scott and Fratcher, supra n. 12, at §157.4; United States v. Cohn, 855 F. Supp. 572 (D. Conn. 1994); First Northwestern Trust Company v. Internal Revenue Service, 622 F.2d 387 (8th Cir. 1980); see also United States v. O’Shaughnessy, 517 N.W.2d 574 (Minn. 1994) (holding that under state law a beneficiary’s interest in a purely discretionary trust is not “property” or “any right to property” within the meaning of the federal tax lien statute before the trustee has exercised its discretionary power to distribute under the trust agreement).
\textsuperscript{16} See infra § II.
SNT following the beneficiary's death be unsuccessful. If so, concerns about the “exception creditor” status of possible governmental claims against SNTs would be unfounded.

Spendthrift protection generally, and UTC spendthrift protection specifically, are not without limits. Spendthrift protection is justified on the notion that a settlor ought to be able to restrict access to a beneficial interest as settlor chooses. Public policy considerations have historically limited spendthrift protection.17

Though substantially revised in the 2005 amendments, UTC §503, which was substantially revised in the 2005 amendments, provides “(b) A spendthrift provision is unenforceable against: . . . (3) A claim of this State or the United States to the extent a statute of this State or federal law so provides.”18 The federal government, through preemption, and the States, through their inherent legislative power, have always had the power to provide, and have provided, that spendthrift provisions do not bar certain of their claims.19 While UTC § 503 previously did not specify the remedy available to a governmental exception creditor, § 503(c) now specifies one remedy for all exception creditors:

(c) A claimant against which a spendthrift provision cannot be enforced may obtain from a court an order attaching present or future distributions to or for the benefit of the beneficiary. The court may limit the award to such relief as is appropriate under the circumstances. 20

Under the law of some states, creditors who have provided necessities to the beneficiary are spendthrift exception creditors. 21 The UTC omits necessities providers

17. Dean Griswold said that “…the bundle of rights known as ownership of property does not embrace an unqualified power of disposition in any way desired. There is no syllogistic basis for the spendthrift trust. If such trusts are valid it is not because the owner of property may dispose of it as he sees fit, but because the particular restriction in question is not contrary to public policy.” Erwin N. Griswold, Spendthrift Trusts (2d ed. 1947). With respect to Dean Griswold’s arguments, it has been said that, “The settlor of a trust for another person should be allowed to insulate the assets and distributions of the trust from the beneficiary’s creditors, but only up to a point. Some claims compel recognition on policy grounds.” A. Emanuel, “Spendthrift Trusts: It’s Time to Codify the Compromise,” 72 Nebraska L.Rev. (1993). See also 2A Scott and Fratcher, supra n. 12, at §157-158.1; Restatement (Third) of Trusts § 58, Reporter’s Notes cmt. a. (2001).

18. Unif. Trust Code § 503(b)(3) is narrower than the rule in the Second Restatement, which grants exception creditor status to the federal government and the State without regard to whether another state statute or federal law so provides.

19. Restatement (Second) of Trusts § 157(d) (1959) and Restatement (Third) of Trusts § 59 cmt. a(1) (2001).

20. See Unif. Trust Code § 503 cmt. (2005), “Subsection (c) provides that the only remedy available to an exception creditor is attachment of present or future distributions. Depending on other creditor law of the state, additional remedies may be available should a beneficiary’s interest not be subject to a spendthrift provision. Section 501, which applies in such situations, provides that the creditor may reach the beneficiary’s interest under that section by attachment or ‘other means.’ Subsection (c), similar to section 501, clarifies that the court has the authority to limit the creditor’s relief as appropriate under the circumstances.”

21. Restatement (Third) of Trusts § 59(b) cmt. c and Restatement (Second) of Trusts § 157(b).
as exception creditors. Accordingly, this aspect of the UTC is more protective of SNTs with respect to creditor claims.

D. The UTC preserves the distinction between support and discretionary trusts for most purposes.

Article 5 of the UTC, which contains the creditor remedy provisions, does not distinguish between discretionary and support trusts. Because of the lack of delineation, there has been commentary asserting that the UTC generally (i.e. for all purposes) eliminates the distinction between discretionary trusts and support trusts. Some critics go even further and charge that under the UTC, the treatment of discretionary trusts will be the same as support trusts. Nothing in the UTC supports these claims. Only in the official comment to §504 is any express reference made to the distinction between support trusts and discretionary trusts, and the comment makes it quite clear that the distinction has been eliminated only for creditor rights purposes. The comment to UTC §504, as amended in 2005, states:

This section, similar to the Restatement, eliminates the distinction between discretionary and support trusts, unifying the rules for all trusts fitting within either of the former categories. Eliminating this distinction affects only the rights of creditors. The effect of this change is limited to the rights of creditors. It does not affect the rights of a beneficiary to compel a distribution. Whether the trustee has a duty in a given situation to make a distribution depends on factors such as the breadth of the discretion granted and whether the terms of the trust include a support or other standard. (Emphasis added)

At one time, under the common law of most states, creditors could not compel distributions from discretionary trusts. For public policy reasons, however, in many jurisdictions judicially created exceptions to that rule evolved, or statutory exceptions were enacted, to permit judgments or court orders for child support, spousal support, or alimony to be satisfied from beneficial trust interests of the parent or spouse against whom the order was made, particularly where the trust contained a support standard. The UTC, in §504(c), merely codifies this very limited exception by granting to a small class of creditors the right to compel distributions from discretionary trusts under two limited circumstances: (i) where the trustee has not complied with a standard of distribution; or (ii) has abused its discretion. The discretionary-support

24. Merric, et. al., in their article “The Uniform Trust Code: A Continued Threat to SNTs Even After Amendment,” supra, n. 1, make the claim “The UTC specifically abolishes the discretionary support dichotomy.”
25. Merric, et. al., in their article “The Uniform Trust Code: A Continued Threat to SNTs Even After Amendment”, supra n. 1, make the unsupported claim, “[T]he UTC redefines the discretionary trust to be nothing more than a support trust under common law. . . .” This claim appears to be a distortion of the Restatement (Third) of Trusts § 60 Reporter’s Notes to cmt. a under which support trusts are treated as discretionary trusts with support standards. See also infra n. 33.
trust distinction no longer exists in this regard in states where child support or spousal support orders or judgments can be satisfied from the debtor-beneficiary’s discretionary trust interest (and there are many such states).26

Because under the UTC the distinction between discretionary trusts and support trusts remains intact for all other purposes, the duties and rights of the trustee and the beneficiary with respect to distributions will continue to differ significantly if the trust is a discretionary trust or a support trust. Common law principles regarding discretionary trusts will continue to apply in determining trustee duties and the rights of beneficiaries.27

Of far more importance than UTC §504’s recognition of the fact that for certain creditor rights purposes the distinction between support trusts and discretionary trusts has already been eroded by the courts, is §504(b)’s nearly complete bar against creditors, including governmental exception creditors, from being able to compel distributions from discretionary trusts.28 Because of this bar, governmental entities that pay benefits to SNT beneficiaries simply lack the ability to reach assets held in an SNT. To clarify the point that the §504(b) bar against the ability to compel distributions applies only to creditors, §504(d) provides:

This section does not limit [i.e. this section does not create] the right of a beneficiary to maintain a judicial proceeding against a trustee for an abuse of discretion or failure to comply with a standard for distribution. (Emphasis added)

Unfortunately, UTC critics assert that this unambiguous provision actually creates a new right in beneficiaries to compel distributions.29 This language, which could hardly be stated more clearly, simply provides that any rights that a beneficiary may have under current state law to compel a distribution are not affected by the removal of creditors’ rights to compel distributions. Under non-UTC law, many cases provide that where a beneficiary has the right to compel a distribution, so does the beneficiary’s creditor.30

Why was the distinction between discretionary and support trusts removed for creditor rights purposes? Most trusts are neither purely discretionary trusts nor purely support trusts, but instead have elements of both. Because of that fact, a growing number of courts have refused to label trusts under review as being one type or

26. See e.g., Restatement (Third) of Trusts § 60 cmt. e(1) and Reporters Notes to cmt. e(1).
27. “Thus, while Article 5 treats discretionary trusts with and without support standards alike, it does not address or change the traditional rules that govern the trustee’s exercise of discretion with respect to making distributions to or for the benefit of the beneficiary.” Newman, Spendthrift and Discretionary Trusts: Alive and Well Under the Uniform Trust Code, supra, n. 23.
28. Under §504, only spouses, former spouses, and children with support orders or judgments for support would be able to compel a distribution from a trust with a support standard, but only if the trustee improperly applied the standard or abused its discretion.
29. See § II(C)(2) of Merric, et. al. “The Uniform Trust Code: A Continued Threat to SNTs Even After Amendment,” supra n. 1, in which they state “U.T.C. § 504 , titled ‘discretionary trusts,’ appears to grant a beneficiary an enforceable right to a distribution.”
30. Restatement (Third) of Trusts § 60 cmt. (e); Clifton B. Kruse, Jr., Third Party and Self Created Trusts—Planning for the Elderly and Disabled Client, 55-61 (3d ed. 2002).
Another, and instead base their decisions upon the intent of the settlor. The elimination of the dichotomy merely reflects what courts have already been doing.\footnote{See Newman, Spendthrift and Discretionary Trusts: Alive and Well Under the Uniform Trust Code, 40 Real Prop. Prob. & Trust J., supra, n. 23, in which he states: “Does the UTC treat a discretionary trust without a support standard as a trust for the beneficiary’s support?” No. Although section 504 (prohibiting most creditors of the beneficiary from compelling discretionary distributions they can reach) and section 501 (providing creditors’ remedies when the terms of the trust do not include a spendthrift provision) do not distinguish between discretionary trusts with and without support standards, with limited exceptions the UTC does not address the rights of beneficiaries – and the duties of trustees – with respect to distributions to be made from such trusts. Because the UTC generally does not address those subjects, they would be governed by common law and principles of equity. Thus, a beneficiary’s right, if any, to receive a distribution from a discretionary trust, with or without a support standard, would be determined under the same rules under the UTC as it would be without the UTC. Under those rules, discretionary trusts without}

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The definitional distinctions between support and discretionary trusts are limpid. Provisions of particular trusts muddy these clear demarcations. When the provision is equivocal or adheres to principles common to both types of trusts, interpretative inconsistencies abound. . . .

Any attempt by this court to hammer the language of this particular trust provision into one of these rigid categories would only breed further inconsistencies in the law. . . . The state of Nebraska remedied the inherent inconsistencies of forcing equivocal trust provisions into traditional categories by creating a third category, a discretionary support trust, which addresses the equivocal provision in its entirety and best contemplates the intent of the settlor. . . . A discretionary support trust is created when the settlor combines explicit discretionary language with language that, in itself, would be deemed to create a pure discretionary trust. . . . The effect of a discretionary support trust is to establish the minimal distributions a trustee must make in order to comport with the settlor’s intent of providing basic support, while retaining broad discretionary powers in the trustee. . . . The rationale behind minimal support lies in the trustee’s fiduciary duties to the beneficiary. . . . If a trustee abuses her discretion and violates her fiduciary duties, the beneficiary, through judicial action, may compel disbursements from the trust for minimal support.

A discretionary support trust harmonizes the seemingly inconsistent terms of the trust.

Professor Alan Newman, the Reporter for the Ohio Uniform Trust Code, has shared his observations regarding the elimination of the distinction, none of which gives credence to the claim that the elimination will make it easier for beneficiaries to compel distributions from discretionary trusts.\footnote{See New, supra, n. 23, in which he states: “Does the UTC treat a discretionary trust without a support standard as a trust for the beneficiary’s support?” No. Although section 504 (prohibiting most creditors of the beneficiary from compelling discretionary distributions they can reach) and section 501 (providing creditors’ remedies when the terms of the trust do not include a spendthrift provision) do not distinguish between discretionary trusts with and without support standards, with limited exceptions the UTC does not address the rights of beneficiaries – and the duties of trustees – with respect to distributions to be made from such trusts. Because the UTC generally does not address those subjects, they would be governed by common law and principles of equity. Thus, a beneficiary’s right, if any, to receive a distribution from a discretionary trust, with or without a support standard, would be determined under the same rules under the UTC as it would be without the UTC. Under those rules, discretionary trusts without}
Assuming, for the sake of argument, that in the context of creditor’s rights the UTC does strip away all protections formerly enjoyed by a pure discretionary trust (such as a purely discretionary SNT with no distribution standard but with precatory SNT language), exactly what would be lost? Only two things:

a) Exception creditors could attach, but not compel, present or future distributions that the trustee decides to make, subject to the court’s ability to limit the award; and

b) Spouses, former spouses, and children with support orders or judgments for support would be able to compel a distribution from a trust that contains a support standard if the trustee improperly applied the standard or abused its discretion.

III. THE UTC WILL NOT MAKE IT EASIER FOR STATES TO DENY BENEFITS TO SNT BENEFICIARIES.

A. Beneficial interests in SNTs are not resources of their beneficiaries.

UTC critics charge that under the UTC, it will be easier for States to deny Medicaid benefits to SNT beneficiaries for the reason that the SNT assets will be treated as the beneficiaries’ countable resources. While this claim is false, an examination of this issue hinges upon whether the beneficiary’s interest in an SNT is a “resource.” The answer as to whether or not an interest in a trust is a resource depends upon the terms of the trust (e.g., whether the trust contains a support standard) and upon whether or not the beneficiary has the right to compel a distribution. As the UTC is generally silent regarding the rights that a beneficiary may have to compel a distribution, the issue ultimately boils down to whether or not the UTC has changed the judicial standard of review in a manner that would make it easier for a beneficiary to compel a distribution. All of these issues are discussed below.

34. The only 3 classes of exception creditors (i.e., those creditors against which spendthrift provisions are not effective) are listed in UTC § 503(b): (1) a beneficiary’s child, spouse, or former spouse who has a judgment or court order against the beneficiary for support or maintenance; (2) a judgment creditor who has provided services for the protection of a beneficiary’s interest in the trust; and (3) a claim of this State or the United States to the extent a statute of this State or federal law so provides.

35. Unif. Trust Code § 503(c).

36. Id., at § 504(c).

37. The question of whether a trust is an available resource for qualification for government means-tested benefits (i.e., whether the beneficiary of the trust has the right to compel a distribution for support) is to be distinguished from the question whether the trust property is available to satisfy the beneficiary’s creditors. See Corcoran v. Dept. of Social Services, 859 A2d. 533 (Conn. 2004).

38. Supra, n. 27.
The CMS State Medicaid Manual has a detailed trust rule that applies to self-settled SNTs, but not to third party-settled SNTs. However, the State Medicaid Manual generally follows SSI rules for Medicaid, and most SSI recipients also qualify for Medicaid (and in many states SSI recipients automatically qualify for Medicaid).

Accordingly, as a general rule, an SNT will not be treated as a resource for Medicaid purposes to the extent that it does not make, and the beneficiary cannot compel the trustee to make, distributions for food and shelter.

Nevertheless, in the eighteen States where Medicaid coverage is not automatically granted to SSI recipients (i.e. the SSI-criteria and §209[b] States), or for institutionalized individuals (institutionalized individuals are not eligible to receive SSI), state law will determine when an SNT is treated as a resource for Medicaid eligibility purposes. In most States, the legislatures or the Medicaid agencies have adopted statutes or rules governing when third party-settled SNTs will be treated as resources. These rules, however, must conform to the “availability” requirements set forth in the United States Code and the Code of Federal Regulations.

It is a fundamental principle of trust law that a grantor may dispose of his or her property in any manner desired, other than dispositions prohibited by law or contrary to public policy. Accordingly, if the settlor intends that the trust supplement rather than supplant the beneficiary’s government benefits, such intent should be controlling. Such a trust should not be deemed an available resource.

In an attempt to treat SNTs as available resources for Medicaid purposes, states occasionally have challenged SNTs (especially SNTs that do not clearly state their purpose of supplementing, rather than supplanting, public benefits) on the basis that the trustee owes an obligation of minimum support to the beneficiary. On the other
hand, there are cases in which trusts that contain an express support standard, but that also grant to the trustee uncontrolled discretion, have been held not to be available resources. As a general rule, purely support trusts are treated as available resources; but, purely discretionary trusts are rarely available resources. The difference typically hinges upon whether or not under state law the beneficiary has the right to compel a distribution for support.

B. When can a beneficiary compel a distribution?

The answer to this question is important, because in most states a trust will be treated as a resource if the beneficiary can compel a distribution, especially a distribution for support. Unfortunately, the UTC is silent on this important question. There are 3 important points to make regarding this question that do involve the UTC.

First, while §504 does prohibit creditors from being able to compel distributions, paragraph (d) of that section does not limit the beneficiary’s right to maintain an action against the trustee for abuse of discretion or failure to comply with a standard of distribution. Section 504(d) does not grant the beneficiary a new right to compel distributions. Rather, it merely states that the §504 ban on the ability of creditors to compel distributions is independent of the ability of beneficiaries to compel distributions when the trustee has abused its discretion or failed to comply with a

44. Alabama Medical Agency v. Primo, 579 So. 2d 1355 (Ala. Civ. App. 1991) (recognizing importance of POMS SI 01120.105 A.2 (1981); City of Bridgeport v. Reilly, 47 A.2d 865 (Conn. 1946) (a reasonable exercise of discretion is not reviewable); Chenot v. Bourdeleau, 561 A.2d 891 (R.I. 1989) (an amalgamation of support and discretionary trust terms but discretionary trust terms control; discretion cannot be forced so long as the trustee acts in “good faith”); First Nat’l Bank of Md. v. Dept. of Health, 399 A.2d 891 (Md.1979) (discretionary trust with support standards but because of use of “absolute and uncontrolled” in defining discretion, the trust was not an available resource); Lang v. Commonwealth Department of Public Welfare, 528 A.2d 1335 (Pa. 1987) (discretionary support trust held to be supplemental); Lineback v. Stout, 339 S.E.2d 203 (N.C. 1986) (a discretionary support trust may be construed as a supplemental care trust); Myers v. Kansas Dept. of Social Services & Rehab., 866 P.2d 1052 (Kan. 1994) (a discretionary trust with standards not available because trustee could decline to pay for medical care and assistance); Department of Mental Health v. Phillips, 500 N.E.2d (Ill. 1986) (no discretion to make payments that would render beneficiary ineligible); Matter of Sykes, 345 N.W.2d 642 (Mich. App. 1983) (discretionary support trust coupled with duty to consider other resources is not available); Zeoli v. Commissioner of Social Services, supra, note 43 (discretionary support trust coupled with precatory language to consider other resources makes the trust supplemental); Tidrow v. Director, Missouri State Div. of Family Services, 688 S.W.2d 9 (Mo. App. 1985) (a discretionary support trust intended for supplemental benefit is “not actually available” and will not disqualify).

45. Kruse, supra n. 30, at 54.

46. Corcoran v. Dept. of Social Services, supra n. 37.
C. Common law rights to compel distributions.

If a trust is a pure discretionary trust with no distribution standard, the beneficiary generally has no ability to compel a distribution, especially if the trustee was given "sole," "absolute," or "uncontrolled" discretion. Therefore the trust is not an available resource.

If a trust is a support trust, a beneficiary generally has the right to compel the trustee to make distributions pursuant to the distribution standard. Accordingly, the trust is an available resource.

There has been much litigation on the issue of whether or not a trust is a support trust. If the trust is discretionary with a support standard, some cases have held that the beneficiary cannot compel a distribution. In these cases, the trust property is not an available resource and the beneficiary is not disqualified from eligibility of means-tested government benefits. Other cases have held that the beneficiary can compel a distribution and that the trust property is therefore an available resource.

47. See Unif. Trust Code § 504 cmt. to subsection (d). "... the power to force a distribution due to an abuse of discretion or failure to comply with a standard belongs solely to the beneficiary. Under UTC § 814(a), a trustee must always exercise discretionary power in good faith and with regard to the purposes of the trust and the interest of the beneficiaries."

48. See Unif. Trust Code § 502 cmt which provides: "Unless one of the exceptions under this article applies, a creditor of the beneficiary is prohibited from attaching a protected interest and may only attempt to collect from the beneficiary after the payment is made." See also Restatement (Third) of Trusts § 58 and Restatement (Second) of Trusts §§ 152-153.

49. Restatement (Third) of Trusts § 50 cmt. b., Reporter’s Notes to cmts. a-b; Restatement (Second) of Trusts § 187; 2A Scott and Fratcher, supra, n. 12, §§ 128.3-128.7; George G. Bogert and George T. Bogert, The Law of Trusts and Trustees §§ 182, 228-230, 424-428, 811 (rev. 2d.ed. 1979).


51. See Restatement (Third) of Trusts § 50 and Restatement (Second) of Trusts § 187.


53. See Kruse, supra, n. 30, at 54 - 70.
question becomes one of settlor intent, to wit: does the settlor demonstrate an intent to supplement the beneficiary’s public benefits or an intent to supplant them? The Comment to UTC §103 underscores the point that it is the settlor’s intent that is paramount. That comment states, “Except as limited by public policy, the extent of a beneficiary’s interest is determined solely by the settlor’s intent.”

Intent is evidenced primarily by the trust’s distributive language, but it can also be determined by precatory statements, and the circumstances of the beneficiary at the time of the trust’s creation. This is illustrated in In Re Leona Carlisle Trust, where the court stated:

The intention of the settlor of the trust will be carried out if it is not contrary to law and public policy. . . . When the trust instrument states an intent to supplement rather than supplant any government financial assistance that is or may be available to the Medicaid recipient, most courts give effect to the settlor’s intent and find the trust is not an available asset. . . . The cases that involve both a discretionary trust and clear settlor intent to supplement rather than supplant government assistance conclude the trust is not an available asset. See id. [Trust Co. of Okla., 825 P.2d 1295], see also Zeoli v. Commissioner of Social Servs., 179 Conn. 83 (1979); Lineback by Hutchens v. Stout, 79 N.C.App 292 (1986).

Many cases, however, are notable for the fact that no examination is made regarding the settlor’s intention in creating the trust.

D. A beneficial trust interest cannot be a resource unless it is “available.”

To determine whether a person is entitled to Medicaid benefits, a state may consider only the income and resources that are “available” to the applicant or recipient. Whether an interest in a trust is a “resource” is a matter of federal law, and while the meaning of “availability” in the context of a third party-settled trusts is not specifically addressed in the United States Code or the Code of Federal Regulations, that issue is addressed squarely in the CMS Program Operation Manual System (“POMS”), and was discussed in the legislative history of the Medicaid Act.

42 U.S.C. 1396a requires: “A State plan for medical assistance must. . .(17) . . . include reasonable standards. . .for determining eligibility. . .which. . .(B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the beneficiary [and]. . .(C) provide for reasonable evaluation of any such income or resources. . . .” (emphasis added)

20 CFR §416.1201(a)(1) clarifies this by providing:
(a) Resources; defined. For purposes of this part L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and

54. See Kruse, supra, n. 30, at 55 – 58.
55. See First National Bank of Maryland v. Dept. of Health and Mental Hygiene, supra, n. 44; see also Tidrow v. Director, Missouri St. Div. of Family Serv., supra, n. 44.
maintenance. (1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).

Similarly, 20 CFR §416.120(c)(3) states, “Resources means cash or other liquid assets or any real or personal property that an individual owns and could convert to cash to be used for support and maintenance. . . .”

The POMS, at SI 01120.200, discusses “availability” in the context of trusts established by third parties. (D)(1)(a) of that section states:

If an individual (claimant, recipient, or deemor) has legal authority to revoke the trust and then use the funds to meet his food, clothing or shelter needs, or if the individual can direct the use of the trust principal for his/her support and maintenance under the terms of the trust, the trust principal is a resource for SSI purposes.

The issue of “availability” is also discussed in Medicaid’s legislative history. A 1965 Senate Report summarizing the newly enacted Medicaid Act stated:

Another provision is included that requires States to take into account only such income and resources as . . . are actually available to the applicant or recipient and as would not be disregarded . . . Income and resources taken into account, furthermore, must be reasonably evaluated by the States. These provisions are designed so that the States will not assume the availability of income which may not, if fact, be available or overevaluated income and resources which are available. 57

State and federal courts have addressed the application of these federal “availability” requirements. The United States Supreme Court has stated that the “availability principle” is aimed primarily at preventing states from imputing or assuming financial assistance from sources who have no obligation to furnish it. 58 The Connecticut Supreme Court stated:

[Un]der applicable federal law, only assets actually available to a medical assistance recipient may be considered by the state in determining eligibility for public assistance programs such as title XIX [Medicaid]. . . . A state may not, in administering the eligibility requirements of its public assistance program pursuant to title XIX . . . presume the availability of asset not actually available. . . . Zeoli v. Commissioner of Social Services, 179 Conn. At 94, 425 A.2d 553. 59

E. Effect of the Mandatory Good Faith Standard on “Availability.”

UTC §814(a) provides: “Notwithstanding the breadth of discretion granted to a trustee in the terms of the trust, including the use of such terms as ‘absolute’, ‘sole’, or ‘uncontrolled’, the trustee shall exercise a discretionary power in good faith and in accordance with the terms and purposes of the trust and the interests of the beneficiaries.” This is one of the 14 mandatory rules of UTC §105 that cannot be

59. See also Corcoran v. Dept. of Social Services, supra, n. 37, and Kruse, supra, n. 30, pgs. 52 – 54.
changed by the settlor. If, in fact, §814(a) enhances beneficiaries’ rights to compel distributions from discretionary trusts, state Medicaid agencies would correspondingly be able to treat more, but certainly not all, discretionary trusts as available resources. Fortunately, §814(a) provides no such enhancement. Even if §814(a) did grant beneficiaries a greater ability to compel distributions, which it does not, a beneficiary would still be unable to compel a distribution from a pure discretionary trust without a support standard or from a discretionary trust that states its purpose as being to supplement rather than to supplant public benefits.

The claim has been made that §814(a) creates a much higher standard for trustee conduct inasmuch as it replaces the current “bad faith” standard.60 Requiring “good faith” appears to be the same standard as one that prohibits “bad faith.” Just as there are a plethora of cases that state the judicial standard of review is a good faith61, a significant numbers of cases state that the standard of review is based upon an abuse of discretion or bad faith standard.62 While these cases frame the standard differently, the effect of their holdings is the same, simply because the standards are the same. Critics have been unable to cite even one case that contrasts the good faith standard from the abuse of discretion standard for the simple reason that no such case exists. In point of fact, the inclusion of §814(a) is just another instance of the UTC’s codification of current trust law. Without changing the meaning, that section could have instead prohibited trustees from exercising discretionary powers in bad faith, or it could have been omitted altogether. Inasmuch as a primary purpose of the UTC is the codification of the common law of trusts, its inclusion, as written, is an accurate reflection of the common law of trusts. The fact that a good faith standard is, and for many decades has been, the same as a standard that prohibits bad faith is illustrated by Sylvester v. Newton,63 where the court stated:

It has been long established as matter of law that the judgment of this court cannot be substituted for the discretion conferred upon fiduciaries fairly, reasonably, and honestly exercised [cites omitted]. The court will substitute its discretion only when that is necessary to prevent an abuse of discretion [cites omitted]. In the instant case the only question is whether the exercise of discretion by the executor complained of was arbitrary, capricious and not in good faith. [emphasis added]


Professor Alan Newman has also pointed out that courts use the terms “bad faith” and “good faith” interchangeably because the former is essentially the absence of the latter.64 In support of his conclusions he cites a California case in which the court said:

…the ‘sole discretion’ vested in an exercise by the trustees in this case…were exercised fraudulently, in bad faith or in an abuse of discretion, in other words an abuse of discretion, it is subject to…review. Whether good faith has been exercised, or whether fraud, bad faith or an abuse of discretion has been committed it is always subject to consideration by the court upon appropriate allegations and proof. In Re: Ferrall’s Estate 258 P.2d 1009 (Cal. 1953).

Professor Newman drives home this point by comparing two recent Colorado cases:

Further, a year after the Colorado Supreme Court stated that if the settlor gives the trustee uncontrolled discretion, the court will not interfere with its exercise unless the trustee “acts dishonestly or from an improper motive, or fails to use his judgment,” [fn: Marriage of Jones, 812 P.2d at 1156. Note that in Jones, the Colorado Supreme Court did not announce a single standard to be applied in Colorado in cases involving a challenge to the trustee’s exercise of discretion. In fact, the case did not even involve such a challenge, but instead decided whether a wife’s interest in a discretionary trust constituted property for purposes of division in a divorce. Id. In holding that it did not, the court described the circumstances under which a trustee’s exercise of discretion will be reviewed in four different ways: (i) “the beneficiary could not force the trustee to pay income or principal unless she could establish fraud or abuse of discretion,” id. at 1156; (ii) “[t]he beneficiary cannot obtain the assistance of the court to control the exercise of the trustee’s discretion except to prevent an abuse by the trustee of his discretionary power,” id.; (iii) “[i]f the settlor manifested an intention that the discretion of the trustee should be uncontrolled, the court will not interfere unless he acts dishonestly or from an improper motive, or fails to use his judgment,” id. (emphasis in original), and (iv) “the beneficiary of a discretionary trust has no contractual or enforceable right to income or principal from the trust, and cannot force any action by the trustee unless the trustee performs dishonestly or does not act at all.” Id.] a lower appellate court in Colorado decided a case in which a trustee with sole and absolute discretion over distributions also was a remainder beneficiary and thus had a conflict of interest with respect to his exercise of discretion. [fn: See In re Estate of McCart, 847 P.2d 184 (Colo. Ct. App. 1992).] In upholding the income beneficiary’s claim for increased distributions from the trust, the opinion characterized the trustee’s conduct as an abuse of discretion, arbitrary and capricious, improperly motivated, and a “breach of his fiduciary responsibilities to act with the utmost good faith and fairness toward the beneficiary [fn: id.].

Scott and Fratcher, in The Law of Trusts, equate an abuse standard to a good faith standard. “To the extent . . . the trustee has discretion . . . [t]he court will not substitute its own judgment for his . . . however the court will not permit him to abuse the discretion. This ordinarily means that so long as he acts not only in good faith and from proper motives, but also within the bounds of a reasonable judgment, the court

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will not interfere.” Moreover, at section 187.2, Professors Scott and Fratcher, in their treatise, note that while the “reasonableness” standard can be waived, when it is waived, the “good faith” standard still applies.

Bogert and Bogert, in The Law of Trusts and Trustees, make similar observations. The discussion on judicial standards of review is contained in §560, where “simple” discretion is distinguished from “absolute” discretion, which is discretion described as “full,” “complete,” “absolute,” or “uncontrolled.” Where absolute discretion is granted to the trustee, Bogert and Bogert observe, “Notwithstanding the fact that a literal interpretation of these grants of absolute and uncontrolled discretionary power would seem to sanction any action taken by the trustee thereunder and to leave the courts powerless to intervene, such a construction has not been given them. . . . Although he gives his trustee great freedom of action in the administration of the trust, he surely must intend the qualification that the trustee shall act with some regard to the purposes of the trust and not make decisions which frustrate the accomplishment of the settlor’s intent, and that he employ his discretion deliberately and with some thought and not recklessly or capriciously but in a spirit of good faith and honesty.” [emphasis added].

Bogert and Bogert also observe that where the trustee is granted absolute discretion, two standards have been used in determining whether the court will review a trustee’s exercise of his absolute discretion. One standard permits judicial review where the trustee acted in bad faith, dishonestly, or some other improper motive. Under this standard the trustee’s discretion need not be exercised reasonably. Under the second standard, notwithstanding the grant of absolute discretion, the trustee’s exercise of that discretion must be reasonable under the circumstances. Under both, “There is agreement that a trustee must act in good faith. . . .” Bogert and Bogert state, “It may be concluded that the only difference in the attitude of the courts with regard to mere discretionary powers and absolute discretionary powers is one of degree, in that they are more easily persuaded to find an abuse of a mere discretionary power than to find an improper use of an absolute or uncontrolled power.” Compare this with the official comment to UTC Sec. 814:

A grant of discretion establishes a range within which the trustee may act. The greater the grant of discretion, the broader the range. . . . Section (a) requires a trustee to exercise a discretionary power in good faith and in accordance with the terms and purposes of the trust and the interests of the beneficiaries. Similar to Restatement (Second) of Trusts Section 187, subsection (a) does not impose an obligation that a trustee’s decision be within the bounds of a reasonable judgment, although such an interpretive standard may be imposed by the courts if the document adds a standard whereby the reasonableness of the trustee’s judgment can be tested. Restatement (Second) of Trusts Section 187 cmt. f [sic; should be i]

Thus, it is doubtful that requiring good faith is substantively different than prohibiting bad faith. It would, therefore, seem that even if §814 places a higher standard on trustees, a grant of extended discretion to the trustee [e.g. “sole” and “absolute”] by the grantor combined with a statement in the trust instrument regarding

65. 2 Scott and Fratcher, supra, n. 14, § 187.
the non-support nature of the trust should combine to defeat easily any attempts by the beneficiary to compel a distribution.

IV. THE UTC DOES NOT GIVE THE GENERAL CREDITORS OF AN SNT BENEFICIARY ENHANCED RIGHTS.

A. The UTC actually lessens the ability of general creditors to compel distributions.

Under UTC §504(b), general creditors have lost any ability that they may have had to compel distributions.66 There are reported cases from at least nineteen states67 in which creditors have been permitted to compel distributions from discretionary trusts. When this has been permitted, the creditor typically has provided support on behalf of a beneficiary of a trust with a support standard where it would have been an abuse of discretion by the trustee to refuse to pay for the support.68 UTC section 504, however, prohibits most creditors from being able to compel distributions, even where the creditor has provided support to or for a beneficiary of a support trust, thereby effectively overruling these decisions.69

66. Compare Estate of Dodge, supra, n. 43 (abuse of discretion for trustee not to invade principal of trust created for beneficiary’s “maintenance and care” to satisfy creditor claim for support); State v. Rubion 308 S.W.2d 4 (Tex. 1957) (abuse of discretion for trustee of discretionary support trust to refuse to pay anything to the state for necessary care). See also Restatement (Third) of Trusts § 60 Reporter’s Notes to cmt. e.

67. 2 Scott and Fratcher, supra, n. 14, §157.2 at n. 10, lists cases from California, Colorado, Connecticut, Illinois, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, New York, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, and Vermont in which this remedy has been permitted. This remedy was also permitted in Ohio in Bureau of Support in Department of Mental Hygiene and Correction v. Kreitzer, supra, n. 43.

68. Estate of Dodge, supra, n. 43; State v. Rubion, supra, note 66; Bureau of Support in Department of Mental Hygiene and Correction v. Kreitzer, supra, n. 43; Restatement (Third) of Trusts § 60 Reporter’s Notes to cmt. e(1).

69. Newman, Spendthrift and Discretionary Trusts: Alive and Well Under the Uniform Trust Code, 40 Real Prop. Prob. & Trust J. supra, n. 23. (Professor Newman states: “Section 504(b) prohibits most creditors from compelling a distribution ‘that is subject to the trustee’s discretion.’ If the terms of the trust require distributions for support (for example, ‘the trustee shall make distributions of income and principal for the beneficiary’s support’), an argument can be made that the prohibition of section 504(b) is not applicable, because the required support distributions arguably would not be subject to the trustee’s discretion within the meaning of section 504(b). For at least four reasons, such an argument would fail. First, section 504(b)(1) makes the general rule applicable to discretionary distributions ‘even if . . . the discretion is expressed in the form of a standard of distribution.’ Thus, the use of a standard of distribution in the terms of the trust is treated by the statute as a grant of discretion over distributions. Second, the comment to section 504 notes that the section does not distinguish between support and discretionary trusts and refers to a provision in the Third Restatement under which support trusts are treated as discretionary trusts with support standards. Third, if such terms – ‘the trustee shall make distributions of income and principal for the beneficiary’s support’ – are not treated as providing for distributions at the trustee’s discretion, presumably they would have to be treated as calling for mandatory distributions . . . however, the 2005 amendments to the UTC explicitly define mandatory distributions to exclude distributions pursuant to a standard. Fourth, the comment to section 506, as
B. SNTs do not need creditor protection in order to fulfill their intended purpose.

While the UTC actually limits, rather than expands, the rights of most creditors, the fact remains that the primary purpose of an SNT is to serve as a vehicle that will provide for the supplemental needs of a disabled beneficiary without affecting the beneficiary’s eligibility for governmental benefits.

Absent State law to the contrary, the OBRA self-settled SNTs never have had any asset protection features, yet they have been able to fulfill their intended purpose despite that fact. Inclusion of a spendthrift provision would be ineffectual in a self-settled SNT, since they are funded with the beneficiary’s assets. UTC §505 merely codifies the prevailing common law rule in this regard: “With respect to an irrevocable trust, a creditor or assignee of the settlor may reach the maximum amount that can be distributed to or for the settlor’s benefit.”

Under the UTC, third party settled SNTs will enjoy the full degree of protection from the beneficiary’s general creditors that they have traditionally had.

V. SUMMARY.

In conclusion, the UTC will not negatively affect SNTs. The UTC will not permit lifetime or postmortem recovery by state governments from SNTs for benefits paid to their beneficiaries. Because of mandatory statutory federal safeguards, the UTC will not assist states in their efforts to deny public benefits to SNT beneficiaries. The UTC will not give general creditors of beneficiaries of self-settled or third party-settled SNTs greater rights than they may already have. The UTC will actually enhance SNT planning because of the Section 504 prohibition against the ability of creditors to compel distributions. Planning is further enhanced by Section 503’s removal of exception creditor status for creditors who provided necessary services or supplies, and the inclusion in both Sections 501 and 503 of the Court’s ability to limit a creditor’s award to such relief as is appropriate under the circumstances. The need for a codification of trust law is obvious. The ABA and a large and growing number of state bar associations, have endorsed the UTC and, as of October 1, 2005, it has been enacted in fifteen States. A critical analysis shows that the UTC is not a threat to SNTs.

amended in 2005, explicitly states that a trust is discretionary even if it includes ‘a provision directing a trustee to pay for a beneficiary’s support.’ (citations omitted.)

70. UTC § 504(b) prohibits most creditors (including creditors who have provided support) from forcing exercise of discretion even if there has been abuse); and UTC §503 eliminates the common law necessities provider from spendthrift protection status.

71. Unif. Trust Code § 505; See also Restatement (Third) of Trusts § 58(2) and cmt. c. and Restatement (Second) of Trusts § 156.

72. Ware v. Gulda, 117 N.E.2d 137 (Mass. 1954) (creditors of a settlor/beneficiary may reach the assets of the self-settled trust, discretionary spendthrift trust); In re: Cohen, 8 P.3d. 429 (Colo. 1999) (where a person creates a spendthrift trust for his own benefit, his transferee or creditors can reach his interest, and where a person creates a support or discretionary trust for his own benefit, his transferee or creditors can reach the maximum amount that the trustee could pay to him or apply for his benefit; citing Restatement (Second) of Trusts § 156) See also Restatement (Third) of Trusts § 60 cmt. f and Restatement (Third) of Trusts § 58(2) and cmt. e.
APPENDIX A

OHIO MODIFICATIONS TO THE UTC THAT PROTECT SNTS

This appendix lists several modifications made in the Ohio Uniform Trust Code ("OUTC," not enacted) that should have the effect of providing additional protection to SNTs. There can be no question but that under the OUTC, SNTs would have enhanced protections not available under current law.

The Ohio UTC Joint Committee (Joint Committee) is composed of the members from the Ohio State Bar Association’s Estate Planning, Trust and Probate Law Section and the Ohio Banker’s League. The Ohio Association of Probate Judges and the Elder Law Committee of the Ohio State Bar Association also provided input. The UTC has not yet been introduced in the Ohio legislature; however, that step is anticipated prior to the publication of these materials. Representing such a diverse group of interests, early in the process the Joint Committee decided to study creditor remedies that currently existed against beneficial trust interests and to determine any differences between current Ohio law and the UTC. After a report on creditor rights was prepared and discussed, the decision was made that, with only few exceptions, Ohio would modify Article 5 of its version of the UTC to codify existing Ohio trust law in the area of creditor rights, rather than change it.

Many more modifications were made than are listed below. Those described in this appendix were made to help protect SNTs, or have the effect of providing additional protection to trust beneficiaries in general. While some of these "protections" are most likely not needed, they nevertheless serve the purpose of removing potential uncertainty in key areas by maintaining the status quo and, in some cases, by affording more protections than are available either under current law or under the final version of the UTC. Certain portions of the OUTC that are quoted below show modifications made by the Joint Committee to the corresponding UTC provision. Other quoted sections of the OUTC are intended to highlight additions made by the Joint Committee that add significant protections for SNTs.

A second factor that needs to be noted is the fact that Ohio, having no official "legislative history," does not allow for official comments. Some substantive material that appears in the UTC comments was moved into the text of the OUTC to help assure the intended result.

I. THE "WHOLLY DISCRETIONARY TRUST"

The Joint Committee determined the protection afforded beneficiaries of common law pure discretionary trusts to be significant. While it is the feeling of the authors that those protections are not lost under the UTC, the Joint Committee, in keeping with its goal of codifying, but not changing, Ohio’s trust law in the area of creditor remedies, proposed the creation of a statutory safe harbor pure discretionary trust. In the proposed OUTC, this trust is referred to as a "wholly discretionary trust" ("WDT"). The benefit of having the status of a WDT is that none of the remedies in
Article 5 of the UTC are available to creditors of the WDT’s beneficiary. Of potentially critical importance to SNTs, the WDT definition does permit precatory language regarding the intended purpose of the SNT.

A. Definition of WDT - § 5801.02(Y)

(Y)(1) “Wholly discretionary trust” means a trust to which all of the following apply:
   (a) The trust is irrevocable.
   (b) Distributions of income or principal from the trust may be made to or for the benefit of the beneficiary only at the trustee’s discretion.
   (c) The beneficiary does not have a power of withdrawal from the trust.
   (d) The terms of the trust use “sole,” “absolute,” “uncontrolled,” or language of similar import to describe the trustee’s discretion to make distributions to or for the benefit of the beneficiary.
   (e) The terms of the trust do not provide any standards to guide the trustee in exercising its discretion to make distributions to or for the benefit of the beneficiary.
   (f) The beneficiary is not the settlor, the trustee, or a cotrustee.
   (g) The beneficiary does not have the power to become the trustee or a cotrustee.

(2) A trust may be a wholly discretionary trust with respect to one or more but less than all beneficiaries.

(3) If a beneficiary has a power of withdrawal, the trust may be a wholly discretionary trust with respect to that beneficiary during any period in which the beneficiary may not exercise the power. During a period in which the beneficiary may exercise the power, both of the following apply:
   (a) The portion of the trust the beneficiary may withdraw may not be a wholly discretionary trust with respect to that beneficiary;
   (b) The portion of the trust the beneficiary may not withdraw may be a wholly discretionary trust with respect to that beneficiary.

(4) If the beneficiary and one or more others have made contributions to the trust, the portion of the trust attributable to the beneficiary’s contributions may not be a wholly discretionary trust with respect to that beneficiary, but the portion of the trust attributable to the contributions of others may be a wholly discretionary trust. If a beneficiary has a power of withdrawal, then upon the lapse, release, or waiver of the power, the beneficiary is treated as having made contributions to the trust only to the extent the value of the property affected by the lapse, release, or waiver exceeds the greatest of the following amounts:
   (a) The amount specified in section 2041(b)(2) or 2514(e) of the Internal Revenue Code;
   (b) If the donor of the property subject to the beneficiary’s power of withdrawal is not married at the time of the transfer of the property to the trust, the amount specified in section 2503(b) of the Internal Revenue Code;
(c) If the donor of the property subject to the beneficiary’s power of withdrawal is married at the time of the transfer of the property to the trust, twice the amount specified in section 2503(b) of the Internal Revenue Code.

(5) Notwithstanding divisions (Y)(1)(f) and (g) of this section, a trust may be a wholly discretionary trust if the beneficiary is, or has the power to become, a trustee only with respect to the management or the investment of the trust assets, and not with respect to making discretionary distribution decisions. With respect to a trust established for the benefit of an individual who is blind or disabled as defined in 42 U.S.C. § 1382c(a)(2) or (3), as amended, a wholly discretionary trust may include either or both of the following:

(a) Precatory language regarding its intended purpose of providing supplemental goods and services to or for the benefit of the beneficiary, and not to supplant benefits from public assistance programs;

(b) A prohibition against providing food, clothing, and shelter to the beneficiary.

B. Mandatory Good Faith Standard - UTC §814(a) and OUTC §5808.14(A)

UTC § 814(a) provides that a trustee must exercise discretionary powers reasonably and “in good faith and in accordance with the terms and purposes of the trust and the interests of the beneficiaries,” regardless of whether the trust instrument describes the trustee’s discretion as, for example, “absolute,” “sole,” or “uncontrolled.” For wholly discretionary trusts, OUTC § 5808.14(A) provides that a reasonableness standard shall not apply.

5808.14

(A) The judicial standard of review for discretionary trusts is that the trustee shall exercise a discretionary power in good faith and in accordance with the terms and purposes of the trust and the interests of the beneficiaries, except that a reasonableness standard shall not be applied to the exercise of discretion by the trustee of a wholly discretionary trust. The greater the grant of discretion by the settlor to the trustee, the broader the range of permissible conduct by the trustee in exercising it.

C. Statutory Elimination of Remedies Against the WDT - OUTC § 5805.03

While the proposed statutory definition and judicial standard of review may be sufficient to give WDTs the complete creditor protection that pure discretionary trusts (i.e. discretionary trusts with no distribution standards) enjoyed under the common law, the OUTC has added a new section, § 5805.03, to make absolutely clear the fact that the Article 5 remedies are not available against interests in WDTs. As Ohio generally does not provide for the judicial sale of discretionary interests, even in the absence of a spendthrift provision, that lack of remedy was codified in the new section:

5805.03 Wholly discretionary trusts.

Notwithstanding section 5805.02(B) of the Revised Code, no creditor or assignee of a beneficiary of a wholly discretionary trust may reach the beneficiary’s interest in the trust, or a distribution by the trustee before its receipt by the beneficiary, whether by attachment of present or future
distributions to or for the benefit of the beneficiary, by judicial sale, by obtaining an order compelling the trustee to make distributions from the trust, or by any other means, regardless of whether the trust instrument includes a spendthrift provision.

D. How a WDT Might Read

The WDT should work well as a SNT. In keeping with the purely discretionary common law trust, a WDT is prohibited from having any type of distribution standard. A limited exception permits precatory language for SNTs regarding the special needs nature of the trust. The inclusion of such precatory language in a WDT could be important to dispel any argument that the trustee can be required to make distributions for the support of the beneficiary. The distribution standard for a WDT-SNT, with precatory language, could be as follows:

The trustee may distribute to, or use for the benefit of, the beneficiary such amounts, or none, of income or principal as the trustee, using sole, absolute and uncontrolled discretion, may determine. The beneficiary is disabled and will rely on public programs for much of her life. I will not always be there to help her and oversee her care. I know that she will have supplemental and special requirements, including a need for advocacy, which will not be provided by the publicly funded programs. It is my desire, but not my direction, that the trustee, in the exercise of the trustee’s sole and uncontrolled discretion, make distributions which permit the beneficiary dignity and grace, enhance the beneficiary’s day to day existence, and allow her the highest possible development of her abilities in a manner that will not jeopardize her eligibility for public benefits. (modified from a distribution standard provided by Cynthia L. Barrett, CELA, of Portland, OR)

II. MANDATORY DISTRIBUTIONS

A. Definition of “Mandatory Distribution” - UTC § 506(a) and OUTC § 5801.02(M)

Prior to the 2005 Amendments to the UTC, “mandatory distribution” was not a defined term, at which time a definition of that term was added to UTC § 506(a). The Ohio definition of “mandatory distributions” is included in the definitional section, OUTC § 5801.02 (which corresponds to UTC § 103) and differs from the UTC definition primarily to state explicitly that a distribution pursuant to a support standard is not a “mandatory distribution” even if the trustee is directed to make support distributions and the trust instrument does not expressly grant the trustee discretion with respect to such distributions.

OUTC 5801.02(M) “Mandatory distribution” means a distribution of income or principal, including a distribution upon termination of the trust that the trustee is required to make to a beneficiary under the terms of the trust. Mandatory distributions do not include distributions that a trustee is directed or authorized to make pursuant to a support or other standard, regardless of whether the terms of the trust provide that the trustee “may” or “shall” make such distributions.”
B. Overdue Distributions/Mandatory Distribution Trusts – UTC § 506; OUTC § 5805.05

As was done in OUTC § 5805.02(D) (the Ohio provision that corresponds to § 503[c] regarding the attachment of distributions by exception creditors), the OUTC adds express language to § 5805.05 (which corresponds to UTC § 506, dealing with the attachment of mandatory distributions) to permit a court to limit the award to take into account the supplemental needs of SNT beneficiaries.

5805.05 Mandatory distribution trusts.

(A) To the extent that a trust which gives a beneficiary the right to receive one or more mandatory distributions does not contain a spendthrift provision, the court may authorize a creditor or assignee of the beneficiary to attach present or future mandatory distributions to or for the benefit of the beneficiary, or to reach the beneficiary’s interest by other means. The court may limit an award under this section to such relief as is appropriate under the circumstances, considering among other factors determined appropriate by the court, if any, the support needs of the beneficiary, the beneficiary’s spouse, and the beneficiary’s dependent children, or, with respect to a beneficiary who is the recipient of public benefits, the supplemental needs of the beneficiary if the trust was not intended to provide for the beneficiary’s basic support. If in exercising its power under this section the court decides to order either a sale of a beneficiary’s interest or that a lien be placed on the interest, in deciding between the two, the court shall consider (among other factors it deems relevant, if any) the amount of the claim of the creditor or assignee and the proceeds a sale would produce relative to the potential value of the interest to the beneficiary.

(B) Whether or not a trust contains a spendthrift provision, a creditor or assignee of a beneficiary may reach a mandatory distribution the beneficiary is entitled to receive if the trustee has not made the distribution to the beneficiary within a reasonable time after the designated distribution date.

III. SPENDTHIRT PROVISIONS

A. Validity of Spendthrift Provisions – UTC § 502; OUTC § 5805.01

Under § 5805.01(A), a spendthrift provision is not valid unless it restrains both voluntary and involuntary transfers of a beneficiary’s interest. The OUTC will likely allow spendthrift protection if the trust permits voluntary transfers only with the consent of the trustee.

5805.01

(A) A spendthrift provision is valid only if it restrains both voluntary and involuntary transfer of a beneficiary’s interest. A spendthrift provision that permits voluntary transfer of a beneficiary’s interest only with the consent of a trustee who is not the beneficiary is valid.
B. Spendthrift Exception Creditors

No decisions were found in Ohio in which former spouses with judgments for unpaid alimony were able to enforce those judgments against spendthrift trusts of which their ex’s were beneficiaries, so former spouses were dropped from the list of exception creditors in the OUTC. For the same reason, dropped from the Ohio list of exception creditors was “a judgment creditor who has provided services for the protection of a beneficiary’s interest in the trust.” In the few Ohio cases in which current spouses and children with judgments for support were able to bypass spendthrift provisions, the subject trusts included a support standard. In order to codify these decisions, the Joint Committee made the modifications to UTC § 503 set forth below. Also added was the statement that the court may limit the award to take into account the support needs of the beneficiary, as well as the supplemental needs of the beneficiary of an SNT that was not created for the purpose of providing support. To make it clear that the only creditors for whom the remedy of attachment was available were the enumerated exception creditors, the OUTC counterpart of UTC § 503(c) was reworded as shown in division (D), below. Lastly, because of concerns about the statement contained in Restatement (Third) that the list of exception creditors can increase over time with evolving public policy (a statement found nowhere in the UTC or its comments), this section adds a new division (E) to provide that the statutory list of exception creditors is exclusive.

5805.02 Exceptions to spendthrift provision.

(A) As used in this section, “child” includes any person for whom an order or judgment for child support has been entered in this or another state.

(B) Subject to section 5805.03 of the Revised Code, a spendthrift provision is unenforceable against either of the following:

(1) The beneficiary’s child or spouse who has a judgment or court order against the beneficiary for support, but only if distributions can be made for the beneficiary’s support under the terms of the trust;

(2) A claim of this state or the United States to the extent provided by the Revised Code or federal law.

(C) A spendthrift provision is enforceable against the beneficiary’s former spouse.

(D) A claimant described in division (B)(1) or (2) may obtain from the court an order attaching present or future distributions to or for the benefit of the beneficiary. The court may limit the award to such relief as is appropriate under the circumstances, considering among other factors determined appropriate by the court, if any, the support needs of the beneficiary, the beneficiary’s spouse, and the beneficiary’s dependent children, or, with respect to a beneficiary who is the recipient of public benefits, the supplemental needs of the beneficiary if the trust was not intended to provide for the beneficiary’s basic support.

(E) The only exceptions to the effectiveness of a spendthrift provision are those described in divisions (B) and (D) of this section, in division (B) of section 5805.05 of the Revised Code, and in sections 5805.06 and 5810.04 of the Revised Code.
IV. MODIFICATIONS SPECIFICALLY TARGETED TO SNTS

A. Claims Against Self-Settled SNTs

While the SNT beneficiary is nominally the settlor of (d)(4)(A) trusts, the trust must actually be created by a parent, grandparent, guardian, or by the court. The assets used to fund the trust can be assets of the beneficiary, but in almost all cases the trusts are, instead, funded with assets that the beneficiary was otherwise about to receive. Viewed in this light, the common law rule, codified by UTC §505, that permits the settlor’s general creditors to reach the trust assets, could be unduly harsh in certain circumstances. For this reason, the OUTC added a new paragraph (3) to division (A) in § 5805.06, to allow the court to limit the award with respect to the OBRA ‘93 self-settled trusts.

5805.06 Creditor’s claim against settlor.
(A) Whether or not the terms of a trust contain a spendthrift provision, all of the following apply:

(1) During the lifetime of the settlor, the property of a revocable trust is subject to claims of the settlor’s creditors.

(2) With respect to an irrevocable trust, a creditor or assignee of the settlor may reach the maximum amount that can be distributed to or for the settlor’s benefit. If a trust has more than one settlor, the amount the creditor or assignee of a particular settlor may reach may not exceed the settlor’s interest in the portion of the trust attributable to that settlor’s contribution.

(3) With respect to a trust created pursuant to 42 U. S. C. section 1396p(d)(4)(A) or (C), the court may limit the award of a settlor’s creditor under division (A)(1) or (2) of this section to such relief as is appropriate under the circumstances, considering among other factors determined appropriate by the court, if any, the supplemental needs of the beneficiary.

B. Methods of Creating Trusts - UTC § 401; OUTC § 5804.01

The methods of creating a trust listed in UTC § 401 do not include court ordered special needs trusts that are authorized by OBRA ‘93. Following the lead of Missouri, the OUTC will likely add subsection (4) to § 5804.01, as follows:

5804.01. A trust may be created by any of the following methods:

(1) Transfer of property to another person as trustee during the settlor’s lifetime or by will or other disposition taking effect upon the settlor’s death;

(2) Declaration by the owner of property that the owner holds identifiable property as trustee;

(3) Exercise of a power of appointment in favor of a trustee; or

(4) A court order.
C. Requirements for creation - UTC § 402; OUTC § 5804.02

UTC § 402 includes among the requirements to create a trust that the settlor have capacity and express an intention to create the trust. Because self-settled (d)(4)(A) trusts and (d)(4)(C) pooled fund accounts are funded with assets of the beneficiary, the UTC treats the beneficiary as the settlor. The disabled beneficiary, however, may lack both the capacity to create a trust as well as the ability to indicate an intention to create a trust. For this reason, the OUTC will likely modify the first two requirements accordingly, again following the lead of the Missouri Bar.

5804.02

(A) A trust is created only if all of the following apply:

(1) The settlor, other than a trust created by a court order, has capacity to create a trust;

(2) The settlor, other than a trust created by a court order, indicates an intention to create a trust;

D. Modification or termination of noncharitable irrevocable trust - UTC § 411; OUTC § 5804.11

Generally, UTC § 411 allows the settlor and all beneficiaries to modify or terminate a trust. Because federal SSI requirement prohibit a beneficiaries of OBRA ’93 self-settled SNTs from having the ability to terminate the trust, members of the Missouri Bar expressed concerns that the Social Security Administration as a basis to deny SSI benefits to SNT beneficiaries in UTC states could use this section. To address those concerns that section was made inapplicable to those types of trust.

(A) If upon petition the court finds that the settlor and all beneficiaries consent to the modification or termination of a noncharitable irrevocable trust, the court shall enter an order approving the modification or termination even if the modification or termination is inconsistent with a material purpose of the trust. A settlor’s power to consent to a trust’s modification or termination may be exercised by an agent under a power of attorney only to the extent expressly authorized by both the power of attorney and the terms of the trust; by the settlor’s guardian of the estate with the approval of the court supervising the guardianship if an agent is not so authorized; or by the guardian of the settlor’s person with the approval of the court supervising the guardianship if an agent is not so authorized and a guardian of the estate has not been appointed. This division applies only to irrevocable trusts created on or after the effective date of this Code, and to revocable trusts which become irrevocable on or after the effective date of this Code. This division does not apply to a noncharitable irrevocable trust described in 42 U.S.C. § 1396p(d)(4).

E. § 5804.18. Irrevocability of OBRA ’93 trusts

In determining, a special needs trust beneficiary’s eligibility for SSI, the Social Security Administration looks to state law to determine whether the trust is irrevocable. In a few states, including Ohio, the SSA takes the position that a trust, which by its terms is irrevocable, is treated as being revocable if it fails to name a remainder beneficiary, or if the remainder beneficiaries are the settlor’s heirs. Many special needs trusts are created by the court through a guardianship. Because Ohio law
does not allow a guardian to make a will for the ward, Ohio courts have required that OBRA ’93 special needs trusts name the ward’s “heirs” or the ward’s estate as beneficiary of the trust upon the settlor’s death following the mandatory Medicaid payback. Using the Doctrine of Worthier Title or the Rule in Shelley’s case, the SSA sometimes takes the position that such a trust is revocable, even if its terms state that it is irrevocable. The OUTC will likely include a new §5804.18 to address this situation.

F. § 5804.18 Irrevocability of trusts created under 42 U.S.C. 1396p(d)(4)

A trust described in 42 U.S.C. §1396p(d)(4) is irrevocable if the terms of the trust prohibit the settlor from revoking it, even if the settlor’s estate or the settlor’s heirs are named as the remainder beneficiary of the trust upon the settlor’s death.

V. ADDITIONAL CHANGES THAT COULD AFFECT SNTS

A. Judicial Termination of Trusts on Public Policy Grounds - UTC § 410, OUTC § 5804.10

UTC § 410 provides that a trust can be terminated if a court determines, among other things, that its purpose has become contrary to public policy. The reference to the possibility that an SNT could terminate upon the finding by any judge of a court of competent jurisdiction that it (or SNTs in general) is against public policy is a matter of concern to many practitioners. In an Ohio case that achieved national notoriety, Young v. Ohio Dept. of Human Services 73 an Ohio Supreme Court Justice, Justice Stratton, in dissent, stated that SNTs are against the public policy of the state of Ohio:

Where a child has reached the age of majority and the obligation to support has ceased, I strongly believe it would be against public policy to allow a parent to create a trust where the trust income or trust corpus can go to the child at the discretion of the trustee, except when such distributions would render the child ineligible for medical assistance from the government.

With a significant number of judges coming down firmly on the side of so-called “personal accountability” and with growing pressures to cut virtually all types of social spending, the Joint Committee felt it best to eliminate the reference to public policy. Our corresponding section to UTC § 410, OUTC § 5804.10, reads as follows:

5804.10 Modification or termination of trust; proceedings for approval or disapproval.

(A) In addition to the methods of termination prescribed by sections 5804.11 to 5804.14 of the Revised Code, a trust terminates to the extent the trust is revoked or expires pursuant to its terms, a court determines that no purpose of the trust remains to be achieved, or a court determines that the purposes of the trust have become unlawful or impossible to achieve.

73. 76 Ohio St.3d 547, 668 N.E.2d 908 (1996).
B. Ability to Compel Distributions

Because Ohio case law provides no basis upon which former spouses are able to compel distributions, the Joint Committee added a provision that states that a spouse who received a judgment while still married would not be able to enforce it against the former spouse following the termination of the marriage. In the one Ohio case a child was able to compel a distribution from a spendthrift support trust that had been established for the benefit of the child’s father. The court attached significance to the fact that the grantor had not expressed an intention to preclude the plaintiff (the grantor’s grandchild) from being able to benefit from the trust. For this reason, the OUTC allows the grantor to expressly provide that a spouse or child of the beneficiary is not to have the ability to compel distributions. Because there is no judicial precedent in Ohio for the judicial sale of discretionary interests, the OUTC added a new division (E) to prohibit such sales. It should be noted that of Division (C) was added to codify the holding of the Ohio Supreme Court in Bureau of Support v. Kreitzer, and that the addition of this provision in other states would likely result in a potentially significant expansion of State remedies. The decision was made in Ohio to codify the Kreitzer ruling in this manner so that the OUTC would remain revenue neutral to the state of Ohio, and also to prevent the judicial expansion of the Kreitzer decision by making it available to other types of creditors or in situations where the trust does include a spendthrift provision.

5805.04 Discretionary trusts that are not wholly discretionary trusts.

(A) As used in this section, “child” includes any person for whom an order or judgment for child support has been entered in this or any other state.

(B) Except as otherwise provided in divisions (C) and (D) of this section, whether or not a trust contains a spendthrift provision, a creditor of a beneficiary may not compel a distribution that is subject to the trustee’s discretion, even if the discretion is expressed in the form of a standard of distribution or the trustee has abused the discretion.

(C) Division (B) of this section does not apply to this state for any claim for support of a beneficiary in a state institution if the terms of the trust do not include a spendthrift provision and do include a standard for distributions to or for the beneficiary under which the trustee may make distributions for the beneficiary’s support.

(D) Unless the settlor has explicitly provided in the trust that the beneficiary’s child or spouse or both are excluded from benefiting from the trust, to the extent a trustee of a trust that is not a wholly discretionary trust has not complied with a standard of distribution or has abused a discretion, both of the following apply:

(1) A distribution may be ordered by the court to satisfy a judgment or court order against the beneficiary for support of the beneficiary’s child or spouse, provided that the distributions may be ordered only if distributions can be made for the beneficiary’s support under the terms of

74. Supra, n. 43.
the trust and that no such distributions may be ordered to satisfy a judgment or court order against the beneficiary for alimony;

(2) The court shall direct the trustee to pay to the child or spouse such amount as is equitable under the circumstances but not more than the amount the trustee would have been required to distribute to or for the benefit of the beneficiary had the trustee complied with the standard or not abused the discretion.

(E) Even if a trust does not contain a spendthrift provision, to the extent a beneficiary’s interest in a trust is subject to the exercise of the trustee’s discretion (whether or not such discretion is subject to one or more standards of distribution), the interest may not be ordered sold to satisfy or partially satisfy a claim of the beneficiary’s creditor or assignee.

C. Rights of Creditors of Settlor of Revocable Trust after Settlor’s Death.

UTC § 505(a)(3), consistent with the laws of most states, provides that if the settlor’s probate estate is inadequate, creditors of the settlor may reach the trust assets after the settlor’s death. Because of a 1939 Ohio Supreme Court decision which held to the contrary, the OUTC removed this provision.
APPENDIX B

GOVERNMENTAL CLAIMS FOR THE REPAYMENT OF MEDICAID BENEFITS

This appendix is a summary of the federal law regarding estate recovery. Note that many states have enacted estate recovery legislation that appears to go beyond the scope of what is authorized by federal law. For an excellent discussion of expanded estate recovery, see the article by Oppenheim and Moschella in 1 NAELA J. 7 (Spring 2005).

Pre-September 3, 1982.

Prior to September 3, 1982, federal law was silent on whether state Medicaid programs could recover payments properly made for qualified beneficiaries. As Medicaid is a governmental benefit paid to eligible individuals, presumably no state recovery rights existed, however there is no law on this point.

TEFRA.

TEFRA, enacted on September 3, 1982, added a new Section 1917 to the Social Security Act, codified as 42 U.S.C. § 1396p, made two significant changes. First, it permitted the states to recover an amount equal to Medicaid benefits properly paid on behalf of individuals who were 65 years of age or older when services were provided by recovery against their estates after death. Second, for a “permanently institutionalized” individual, the states were permitted to impose a lien against the Medicaid recipient’s real property prior to death “on account of medical assistance paid.”

OBRA 1993.

In 1993 federal law was amended to require estate recovery, and to lower the age of the recipient against whose estates it could be sought from 65 to 55. The protections for spouses, certain children and siblings, and all cases where hardship might be shown, remained unchanged. States were authorized to place post-death liens (as contrasted with the pre-death liens authorized by TEFRA) on real estate to protect the state’s interest in the property of Medicaid recipients. In addition, recovery was to be sought from the estates of permanently institutionalized adults, regardless of age.

To implement the OBRA ’93 amendments, CMS added Section 3810 to the State Medicaid Manual, “Medicaid Estate Recoveries,” which can be found at http://www.cms.hhs.gov/manuals/45_smm/sm_03_3_3800_to_3812.asp

Pre-Death Liens.

TEFRA liens were, and remain, the only liens that permitted prior to the death of the Medicaid recipient. Pre-death liens may be imposed upon the homes of living Medicaid recipients, regardless of age, who have been determined (after notice and an opportunity for a hearing) to be “permanently institutionalized” and not likely to return
home. If, however, the Medicaid recipient is able to return home, the state must dissolve the liens.

In addition to the restrictions discussed below, states may not place a TEFRA lien on an individual’s home if the spouse or the individual’s child who is under age 21, blind, or disabled lawfully resides in the home.

Post-Death Liens.

Post-death liens (also known as non-TEFRA liens or estate liens) must follow state law, although federal law dictates certain notice requirements. While estate recovery was made mandatory by OBRA ‘93, the use of post-death liens is optional, federal law permitting states to file “post-death,” or “estate recovery” liens against the real property of persons who are permanently institutionalized and those who received Medicaid services after age 55, whether or not they were received in an institution.

A post-death lien can only be placed on real estate owned by the Medicaid recipient. If the spouse owns the home, a lien cannot be used. While it appears as though states may place a post-death lien on the home during the lifetime of the surviving spouse if the recipient owned the home, the lien cannot be enforced during the lifetime of the spouse. In addition, the Nevada Supreme Court, in State of Nevada v. Estate of Ullmer, addressed the enforcement of liens during the lifetime of the community spouse. The Court held that where a lien is imposed following the death of the institutionalized spouse, but during the lifetime of the surviving spouse, the lien must clearly and unequivocally provide that the state will release it upon the surviving spouse’s demand pursuant to any bona fide sale or financial transaction involving the home.

Restrictions Applicable to Both Pre- and Post-Death Liens.

If a lien of either type is placed on an individual’s home, adjustment or recovery (i.e. enforcement of the lien) can only be made after the death of the surviving spouse. Additionally, no lien can be enforced if there is a sibling of the individual residing in the home who was also residing in the home for at least one year immediately before the date of the individual’s admission to the medical institution. Further, no lien can be enforced if there is a live-in caregiver a son or daughter of the individual (who was residing in the individual’s home for a period of at least two years immediately before the date of the individual’s admission to the medical institution). The State Medicaid Manual adds an additional requirement that the sibling or caregiver child must have continuously resided in the home since the date of institutionalization.

All States are required to establish procedures and standards for waiving recovery to avoid “undue hardship.”

No state may impose either a pre-death or a post-death lien unless it amends its “State Plan” that is mandated by 42 U.S.C. § 1396a(a)(1) and submits the amended plan to CMS for approval. The State Plan amendment, besides stating the state’s intention to impose liens, must address the manner in which the state will handle undue hardship waivers and provide for advance notice of any proposed recovery, and specify the hearing and appeal rights and the time frames involved.
LAWYERING FOR OLDER CLIENTS: A NEW PARADIGM*

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I. INTRODUCTION

As the law changes, so does the practice of law. Some of the services that Elder Law attorneys have traditionally provided are declining in demand. The number of clients requiring estate tax planning is declining with the reduction and possible elimination of the federal estate tax. Medicaid planning options are increasingly under attack by the government on both the state and federal level.1

At the same time, attorneys are confronting new competition that threatens their livelihoods. The number of attorneys practicing Elder Law has increased dramatically.2 Legal services are now being out-sourced to English speaking attorneys in India. Traditional legal documents are being sold on the Internet or prepared by state-certified non-lawyers, Certified Legal Documents Preparers or Legal Documents Assistants.3 Clients are using the Internet rather than lawyers to obtain legal information and legal forms. Elder Law and estate planning services are now being provided by large and well-capitalized financial institutions and accounting firms. In addition to the legal profession, our older clients are also being provided with advice and services


2. The membership of the National Academy of Elder Law Attorneys (NAELA) has increased from about 40 members in 1988 to about 5000 members in 2005. In addition to NAELA members, there are many other attorneys practicing Elder Law on a full or part time basis.

from Certified Senior Advisors (CSA), Seniors Real Estate Specialists (SRES), insurance agents Certified in Long Term Care (“CLTC”), accountants providing Elder Care services, financial planners, social workers and geriatric care managers. The unauthorized practice of law rules have not prevented large and well-capitalized financial institutions and accounting firms from providing traditional Elder Law services such as estate and planning, Medicaid planning or fiduciary administration services.

Clearly, the business environment in which Elder Law firms are practicing has changed and continues to change rapidly. We no longer practice in a supplier driven environment in which we are protected from outside competition by the unauthorized practice of law rules. While law firms have never had a monopoly on capital, now they no longer have a monopoly on knowledge. We are currently in a consumer driven environment with international competition from many different professions and industries. The Internet and other technologies have dramatically increased the pace of change and the ability of firms to provide services across state and national borders.

We are faced with structural long-term change rather than cyclical changes in the business environment, not just the variable demand of a normal business cycle. We must confront this new reality or become immaterial and obsolete. In our opinion, it will not be sufficient to simply do what we have done in the past.

How should Elder Law attorneys respond to and confront this new reality? Compared to many of his or her competitors, the typical Elder Law attorney has a practice with limited capital and business expertise. Some attorneys have turned to marketing, but we believe marketing by itself is not the answer. Elder Law attorneys need to innovate with a new practice model. The new model should focus on our core client base (i.e., the elderly), but should also provide new, value-added, holistic solutions to our clients’ most pressing, unmet needs. These new solutions will require the Elder Law attorney to expand the scope of his or her services and advice. In the future, success—
ful Elder Law firms will not succeed by being based solely upon preparing legal documents or only providing traditional legal services; rather, Elder Law firms will have to provide nontraditional services and advice to assist their core client base. We believe clients will seek out providers of such complete, value-added services.

Who is our core client base and what are their unmet needs? Elder Law attorneys work with three groups of clients: the active elderly, age 65 to 75; the elderly, age 75 to 85; and the very elderly, age 85 and over (the fastest growing age group). There are over 35 million Americans over age 65. In this category, 4.6 million are over age 85 and 60,000 are over age 100. Over 50 percent of women, as well as 30 percent of men who reach 65, will live until age 85. Clients age 85 or older are usually women. Women in every age group have a longer life expectancy than men.6

While Americans are living longer than ever before, these longer life spans pose a new set of challenges. Nearly all elderly Americans encounter severe chronic illness and disability in the last stages of life. Many of the elderly population will likely be disabled for months, perhaps years, by a chronic condition or disease such as dementia, heart disease, emphysema, stroke, diabetes, or one of a few and certain cancers (e.g., breast and prostate cancer). In a fairly recent New York Times article, Jane Brody writes:

As deaths from heart attacks decline and life expectancy rises, death has become a protracted process for more and more people. Accompanying this trend is a growing need for medical professionals and families to understand what happens during the last weeks, days and hours of life and what kind of action, or inaction, is most likely to bring a comfortable, peaceful, even beautiful end.7

While many Americans plan for the disposition of their property after their deaths, relatively few plan for the end of their lives. Elder Law attorneys, whose focus is already on end-of-life concerns, have the opportunity to address those concerns for their client. Doing this, however, requires that they shift their services by ceasing to solely focus on the preparation of legal documents, and instead assist clients with their end-of-life concerns. This will require multi-disciplinary professional services, including law, accounting, insurance and investment advice.

Elder Law firms have customarily provided traditional estate and legal services to elderly clients and their families. These legal services have included preparation of legal documents such as wills, powers of attorney and trust agreements; tax planning combined with end-of-life property management and health decisions; public benefits and estate planning related to disability and public benefits and tax return preparation; assisting with the creation and administration of guardianships and conservatorships; and fiduciary representation and Medicaid asset protection planning. In this article, we will review other services or solutions that have not been traditionally provided by

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Elder Law firms; services likely important to clients within the last five years of their life expectancy (“Older Clients”), including insurance, end of life health care and decisions, financial advice and assistance, and bereavement. We will then briefly consider areas not part of traditional Elder Law: self-settled special needs trusts, serving as fiduciary, fiduciary litigation and dispute resolution, and three allied financial services: selling insurance, investments, and real property brokerage.

These services and solutions include:

- Information concerning insurance coverage;
- Avoiding inappropriately aggressive healthcare;
- Obtaining and refusing treatment that reflects the client’s wishes;
- Minimizing the client’s financial burdens and maximizing financial opportunities;
- Helping the client’s family with bereavement; and

Six other non-traditional services that should be considered by Elder Law firms:

1. Drafting and implementing Self-Settled Special Needs Trusts
2. Serving as a Fiduciary
3. Fiduciary Litigation and Dispute Resolution
4. Providing Insurance Products
5. Providing Investment Products
6. Real Estate Commission Referral Fees

II. PROVIDING INFORMATION ABOUT INSURANCE COVERAGE

A. Medicare and Medigap Supplements

The cost of health care and health insurance coverage is critical for our clients. The choices that they must make in obtaining health insurance coverage are complex and are constantly evolving. Elder Law firms should consider advising clients concerning health insurance coverage, elections and options.

Medicare is the national health insurance program with one set of rules for the entire country. Its covers individuals who are 1) age 65 or older and entitled to Social Security retirement insurance, and 2) younger individuals entitled to Social Security disability benefits (after a two year waiting period). In addition, those individuals who are not otherwise eligible for Medicare, but who are over the age of 65, may purchase coverage. Since 1963, federal employees have been allowed count their employment toward eligibility for Medicare Part A, the hospital insurance component of Medicare.

Medicare is an evolving program that offers increasingly difficult choices to those who participate. In 1997, Congress amended the Medicare program to include Part C,

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which adds a variety of options for the receipt of services\textsuperscript{10} while retaining the original traditional fee for service in the Medicare program. In 2003, the Medicare Act\textsuperscript{11} revised Medicare Part C\textsuperscript{12} and added the new Medicare Part D.\textsuperscript{13} Under Part C, beneficiaries may elect to obtain benefits under a Medicare Advantage Plan rather than under traditional Medicare Part A and B. In any geographic area, there may be one or more Medicare Advantage Plans\textsuperscript{14} that offer various supplemental benefits for a separate premium, which will vary from plan to plan. When the new Medicare Part D prescription drug benefit goes into effect in 2006, individuals will have to affirmatively enroll in a prescription drug plan. Each plan will provide only a limited number of drugs from each class, a formulary; plans will be able to change their formulary on sixty days notice, and individuals will only be able to change their plan once a year.

Our clients will be confronted with choosing between several, if not many, different Medicare Part D drug plans. These plans will have different drug formularies and different premiums. No one plan will be appropriate for all of our clients. If they are denied coverage for a particular medication, they are confronted with a complex, five-step appeal process. The 2003 Medicare Act also increased the complexity of choices for Medigap\textsuperscript{15} insurance. Up to now, our clients have been faced with choosing among ten forms of Medigap coverage. In the future, that choice will become even more confusing. In the 2003 Medicare Act, Congress changed Medigap health insurance plans H, I, and J and created two new Medigap plans, K and L. Beginning in 2006, Medigap Plans H, I, and J may not be sold or renewed to anyone who is enrolled in Medicare Part D. Medicare Part D participants will not be allowed to buy existing Plans H, I and J. Two new plans will also be offered. Plan K will cover 50 percent of cost sharing applicable under Medicare parts A and B, except for the Part B deductible. It will cover 100 percent cost sharing for preventive benefits, all inpatient hospital coinsurance and 365 extra lifetime days of inpatient hospital coverage. There will be a limitation on annual out-of-pocket expenses under Parts A and B of $4,000 adjusted for inflation. Plan

\begin{enumerate}
\item Under Part C, beneficiaries may obtain benefits through one of a variety of PPO, PRO or HMO plans, called the rubric “Medicare Advantage Plan(s).” Medicare Advantage Plans include preferred provider organizations (PPO), provider sponsored organizations (PSO), and health maintenance organizations (HMO). It is also important to note that PPOs are “preferred provider organizations” and PROs are “provider-sponsored organizations.”
\item Centers for Medicare and Medicaid Services, \textit{Medicare Prescription Drug, Improvement, and Modernization Act of 2003} (last accessed September 24, 2005).
\item Final rules implementing the new Medicare Part C are published in 42 CFR Parts 417, 422, CMS-4069-F (January 28, 2005).
\item Final rules implementing the new Medicare Part D are published in 42 CFR Parts 400, 403, 411, 417, 423 CMS-4068-F (January 27, 2005).
\item Medicare Advantage Plans include preferred provider organizations (PPO), provider sponsored organizations (PSO), and health maintenance organizations (HMO).
\item Medigap health insurance plans are provided by private health insurance companies to supplement Medicare coverage and sometimes provide services not included in Medicare. Generally, federal law requires insurers to sell Medigap insurance policies which are one of a set of standard policies: Plans A through J. Beginning in 2006, Plans K and L will be added.
\end{enumerate}
L will contain the same provisions except that it will cover 75 percent of cost sharing and the limit on annual expenses will be $2,000.

Finally, the 2003 Act also made changes for those who are eligible for both Medicare and Medicaid (“dual-eligibles”). Beginning in 2006, dual-eligibles will get prescription drug coverage only through the Medicare Part D benefit. Medicaid will not pay for any drugs, even those not included in the individual’s Part D plan. Dual-eligibles will be enrolled automatically in a Part D plan in the fall of 2005 and will have the option of changing plans before the drug benefit becomes available in 2006. Dual-eligibles will pay no premium, no deductible, and co-pays that do not exceed $3 per prescription and will have no gap (the doughnut) in coverage.

Is the federal government providing our clients with the information and assistance they need to make decisions about Medicare programs and benefits? The answer is no. The New York Times reported that the Government Accountability Office (GAO) found that the Centers for Medicare and Medicaid Services’ toll free number gave callers inaccurate responses to questions 29 percent of the time and gave no answer 10 percent of the time. The same report stated that Medicare officials prepared scripts for staff to use in answering questions about Part D, but the GAO found that the public information, staff telephone operators “did not seem to know enough” to choose the right script or did not understand it.

We believe older clients will welcome Elder Law attorneys assisting them in making these difficult decisions and managing their health insurance records. Elder Law attorneys adding health insurance advice to their services may want to consider obtaining health insurance licenses (and appropriate errors and omissions coverage). Although such licensing is not generally required for attorneys giving such advice, Elder Law attorneys adding health insurance advice to their services should consider obtaining health insurance licenses and appropriate E&O insurance.

B. Long-Term Care Insurance

Many of our older clients require long-term care in a nursing home. Others will require long-term care in an assisted living facility or at home. In the past, it was generally believed that before the advent of assisted living on a national scale, an individual reaching age 65 had a 43 percent chance of needing long-term care in a nursing home. For those that reach age 80, the chance increases to 50 percent. This statistic

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17. Generally, attorneys, certified public accountants and trust officers who are acting in their normal course of employment are not required to hold an insurance license to give advice about life or health insurance policies for a fee. See e.g., Virginia Code § 38.2-1837 (2003).
18. Long-term care refers to a broad range of medical, personal and environmental services designed to assist individuals who have lost their ability to remain completely independent in the community. Long-term care is care rendered for an extended period of time, usually more than 90 days. Depending on the severity of the impairment, assistance can be rendered at home, in an assisted living facility or a nursing home.
19. John Hancock, Long-Term Care Marketing Guide 29 (December 1994).
is probably no longer valid because it predates the advent of the assisted living industry. Nevertheless, including assisted living and home care, it appears likely that a majority of adults ages 65 and above will require some form of long-term care. For those that reach age 80, the chance increases to 50 percent.21

Long-term care costs are a major concern for many of our older clients. Nationally, custodial nursing home care now costs approximately $55,000 to $70,000 per year, with costs rising every year. Care in an assisted living facility in 2005 ranges from between $3,000 and $6,000 per month, depending on the area of the country in which the facility is located and the level of care which the individual requires. Care provided by an in-home care agency in 2005 will frequently cost $18 per hour or about $3,500 per month for unskilled care.

Many of our clients will be unable to pay the cost of long-term care out of income or savings, while meeting their other obligations such as providing for their family. Where the client does not have a pre-existing condition that would preclude the purchase of long-term care insurance, an Elder Law attorney can discuss with the client the advisability of purchasing it.22 However, many of our older clients will have failed to purchase long-term care insurance prior to suffering a disability. This insurance coverage will frequently not be available after the on-set of a disability.

C. Life Insurance

An Elder Law attorney should provide the client with insurance advice about converting their life insurance to cash during their lifetime by surrendering the policy for its cash value, borrowing against the policy, loans, or entering into viatical or settlements, Life Settlements, or Accelerated Death Benefits. Generally, an Elder Law attorney may charge his or her client for such advice concerning policy loans, surrendering the policy, Accelerated Death Benefits, Viatical Settlements and Life Settlements without obtaining an additional license from the state.23 However, some Elder Law attorneys who regularly provide insurance advice and charge fees for this advice are obtaining life insurance licenses which permit the attorney to sell to his clients, with appropriate disclosure, products such as long-term care insurance, fixed annuities and life insurance policies. Any attorney who sells insurance products should review and com-

21. Id.
23. Generally, attorneys, certified public accountants and trust officers who are acting in their normal course of employment are not required to hold an insurance license to give advice about life or health insurance policies for a fee. Additionally, an attorney, accountant or financial planner who is retained to represent the viator, is generally not required to obtain a viatical settlement broker’s license. See e.g., Virginia Code § 38.2-1837, 38.2-5700 (2003).
ply with the applicable legal ethics rules before selling insurance products to his clients.

D. Viatical Settlements

The secondary market for life insurance is a recent phenomenon that arose in the 1980s as a result of the AIDS epidemic and subsequent need by individuals to obtain funds to pay for medical care and maintain their standard of living. Viatical settlement firms developed to facilitate the sale of life insurance policies owned by individuals with a terminal illness to investors, enabling them to obtain funds to pay for medical care and maintain their standard of living.24

A viatical settlement contract is a written agreement between a viatical settlement company and the owner of a life insurance policy, including the insured, under a group policy (the viator), who owns a life insurance policy or who is covered under a group life policy and who is terminally25 or chronically ill.26 Viatical settlement contracts are not the same as Accelerated Death Benefits (ADB). Viatical settlements can be a good alternative for policyholders who do not want to surrender their policy to their insurer to obtain the cash value, or if their policy does not provide ADB. As with life insurance death benefits, the proceeds from viatical settlements are exempt from federal income taxation.27

Using viatical settlements, individuals with terminal or severe chronic illnesses sell their life insurance policies to a viatical settlement company and are often paid more for a policy than they would receive under an ADB clause or by surrendering the policy for its cash value. The viatical settlement company requires that the policy must have been in force beyond the two-year incontestable period (2years). The price paid for the policy depends on the insured’s actual life expectancy, based on a specific underwriting review, and the cost of future premiums, as well as the amount of the death benefit. The National Association of Insurance Commissioners has adopted model guidelines for fair payment, which provides that persons insured should receive any-

25. IRC § 101(g)(4)(A) (2004) defines the term “terminally ill individual” as an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of the certification.
26. IRC § 101(g)(4)(B) (2004) defines the term “chronically ill individual” as the meaning given such term by IRC § 7702B(c)(2) (2004). This definition means any individual who has been certified by a licensed health care practitioner as (i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity, (ii) having a level of disability (as determined by regulations) similar to the level of disability described in clause (i), or (iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. The individual must be re-certified every 12 months.
27. I.R.C. § 101(g)(2) (2004). The proceeds must be paid to a chronically or terminally ill individual by a qualified viatical settlement provider.
where from 50 percent to 80 percent of the policy face value. After the viatical settlement company purchases a policy, the new policy owner, who is responsible for paying premiums, receives the death benefit upon the death of the insured.

States require that viatical settlement providers and brokers be licensed. Frequently, the viatical settlement contract must be filed with and approved by the state and the insured must be provided with an approved disclosure form prior to entering into a viatical settlement contract. Various states also:

- Regulate the form of payment;
- Prohibit discrimination on the basis of race, age, sex, national origin, creed, religion, occupation, marital status, or sexual orientation;
- Prohibit finder’s fees to a viator’s attorney, physician, accountant or other person providing professional services to the viator;
- Regulate advertising of viatical settlements; and
- Regulate the frequency that the viatical settlement provider may seek health information about the viator.

E. Life Settlements

“Life settlement firms” were the response of the secondary market for life insurance policies to the viatical settlement firms’ two-year life expectancy requirement. Life settlements are similar to viatical settlements in that an insurance policy is sold to a third party. The policy owner receives cash for the policy and the buyer, who becomes the new policy owner, continues to pay the premiums, and receives the death benefit when the insured dies. Unlike a viatical settlement, the insured does not need to have a catastrophic or life-threatening condition to enter into a life settlement. A typical candidate for a life settlement is a high net worth individual age 65 and over with a life expectancy of 15 years or less, a change in insurability since the policy was issued, and a life insurance policy with a face amount of at least $250,000. Persons who can no longer afford to pay the premiums on their life insurance policies are also candidates for life settlements, as it may be a better option than cashing in the policy or letting it lapse.

28. Virginia requires a minimum payment based on the insured’s life expectancy: Less than 6 months: 80 percent; at least 6 months but less than 12 months: 70 percent; at least 12 months but less than 18 months: 65 percent; and at least 18 months but less than 25 months: 60 percent. If the insured’s life expectancy is 25 months or more, the compensation must be at least the greater of the cash surrender value at the time of the transaction or the then available accelerated death benefit in the policy. See Virginia Administrative Code § 14VAC5-71-60 (2003).


30. See e.g., Virginia Administrative Code § 14VAC5-71-35 (2003).

31. See e.g., Virginia Administrative Code § 14VAC5-71-90-92 (2003). See also Maple Leaf Financial, State-by-state Laws for Viatical and Life Settlements http://www.stonestreetfinancial.com/Compliance/compliance.asp (last accessed October 2, 2005). This website provides links to each state’s laws, regulations, current legislative bills and broker license requirements.
Because life settlements have significantly different tax consequences from viatical settlements, the policy owner should consult with their tax advisor. The difference between the sales proceeds and cost basis is taxable gain. Some life settlement companies and tax experts claim that the difference between the cost basis and the cash value is ordinary income and treat the rest of the difference between the cost basis and the sales proceed as capital gain. Capital gain treatment, however, is uncertain, and to date there are no reported Internal Revenue Service rulings on this issue. When the insured dies, the life settlement company recognizes the difference between the insurance proceed and the cost basis as ordinary income.\(^32\)

Regulation of life settlements varies by state. For example, some states, like Virginia, include life settlements within their laws and regulations pertaining to viatical settlements.\(^33\) Typically, the life settlement process involves several steps. Initially, a detailed health history is obtained to determine the insured’s life expectancy. The life settlement firm then analyzes the policy structure and pricing, and determines if the issuing insurance company meets minimum financial strength ratings. The life settlement firm then calculates the purchase price for the policy so that the firm can earn a return of 12 to 15 percent, with commissions of 10 to 15 percent of the purchase price paid to the insurance salesperson or soliciting agent. The policy owner should obtain several purchase offers and an independent policy analysis to determine if the proposed life settlement is in the policy owner’s best interest.

F. Accelerated Death Benefits

Until recently, traditional life insurance policies provided cash benefit payments only in the event of the insured’s death (or in the rare case of an insured living to a contract’s maturity date). The only way an owner could access a whole life insurance policy’s cash value while living was through a policy loan or policy surrender (or partial withdrawal in the case of a universal life insurance policy). Term life insurance, of course, has no cash value.

The emergence of the viatical and life settlement firms prompted life insurance companies to develop an alternative, known as Accelerated Death Benefits (ABD). The ADBs permit the policy holder to get anywhere from between 25 percent to nearly 100 percent of their benefit while they are still living. Today, ADB benefits are frequently included as a provision in both individual and group\(^34\) life insurance policies.

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33. See e.g., Code of Virginia § 38.1-6000 et seq. (2004) and Virginia Administrative Code § 14 VAC 5-71-10 et seq. (2003). The Code of Virginia was amended in 2003 to expand the definition of “viatical settlement contract” to include all sales of life insurance policies, not just policies in which the insured has a catastrophic or life-threatening illness. The definition does not include accelerated death benefits provisions contained in life insurance policies.
34. See e.g., Virginia Retirement System, Group Life Insurance Program http://www.varetire.org/members/faq/insurance.html#eight (last accessed October 1, 2005).
ADB\textsuperscript{35} is defined as benefits payable:

- To a policy holder, during the insured’s life, in anticipation of death or on the occurrence of a specified life-threatening or catastrophic condition as defined in the policy;
- That reduce the death benefit otherwise payable under the life insurance policy; and
- That are payable on the occurrence of a single qualifying event that results in the payment of a benefit amount fixed at the time of acceleration.

The event that will qualify the policy holder for an ABD varies by company, product and state. During the 1990s, most ADB provisions defined a qualifying event as a life expectancy of 12 months or less. Since 2001, because of competition with life settlement firms, some life insurance companies lobbied for an expanded definition of “qualifying events.” For example, in July of 2002, Virginia amended its administrative code to define “qualifying event”\textsuperscript{36} as follows:

- A medical condition that would result in a drastically limited life span as specified in the policy, for example, 24 months or less;
- A medical condition that requires extraordinary medical intervention, such as a major organ transplant or continuous artificial life support, without which the insured would die;
- Any condition that usually requires continuous confinement in an eligible institution if the insured is expected to remain there for life;
- A medical condition that would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span;
- A condition where a qualified health care provider or court of competent jurisdiction has determined that the insured is no longer able to perform at least two activities of daily living; or
- A condition for which a qualified health care provider or court of competent jurisdiction has determined that the insured requires direct supervision by another person during the majority of each day to protect the health and safety of the insured or any other person.

Similarly, in 2002, the New Jersey Department of Banking and Insurance concluded that “the permanent inability to perform two of the six activities of daily living (bathing, continence, dressing, eating, toileting and transferring) or the presence of a debilitating cognitive impairment constitutes a qualifying event for purposes of payment of an ADB.\textsuperscript{37} It is likely that other states will likely follow this trend in expanding the definition of qualifying event, although many life insurance companies have retained restrictive qualifying event definitions that require a life expectancy of six months or less.

\textsuperscript{35} See e.g., Virginia Administrative Code 14VAC5-70-40 (2003).
\textsuperscript{36} See e.g., Virginia Administrative Code 14VAC5-70-40 (2003).
\textsuperscript{37} New Jersey Department of Banking and Insurance, Division of Insurance, Bulletin No. 02-04 http://www.state.nj.us/dobi/blt02_04.htm (last accessed October 3, 2005).
The ADB provision must include the option to take the benefit in a lump sum, the benefit may not be made payable as an annuity for the insured’s life of the insured, and the policy may not restrict the use of the ADB.\textsuperscript{38} For example, a life insurance policy with a $200,000 death benefit that provides for a 75 percent ADB provision would pay up to $150,000 to an elderly person suffering from dementia who is unable to care for themselves. The remaining $50,000 would be payable on the insured’s death.

Though the insurer may charge an additional premium charge for inclusion of an ADB provision in a life insurance policy, it is usually provided at no increase in premium. Many companies charge interest on the amount of the ADB paid, and some charge an administrative fee to make up for what the company would have earned had the money not been withdrawn from the policy, and some charge an administrative fee.

When a policy owner or certificate holder requests ADB, the insurer is frequently required to give the owner, and any irrevocable beneficiary, a disclosure document showing the effect that the ADB payment of the accelerated benefit will have on the policy’s cash value, accumulation account, death benefit, premium, policy loans and policy liens. The disclosure document will state that receipt of ADBs may adversely affect the recipient’s eligibility for Medicaid or other government benefits. In addition, it will also counsel the policy owner that receipt of an ADB may be taxable and assistance should be sought from a personal tax advisor. When a previous disclosure document becomes invalid as a result of further acceleration of the death benefits, the insurer should send a revised disclosure document to the policy owner and any irrevocable beneficiary. Upon agreeing to accelerate death benefits, the insurer should issue an amended schedule page to the policyholder or notify the certificate owner under a group policy to reflect any new, reduced, in-force face amount of the contract.\textsuperscript{39}

Any ADB received by a terminally ill individual or a chronically ill individual is excluded from gross taxable income. This exclusion for terminally ill individuals is unlimited in amount.\textsuperscript{40} The exclusion for the chronically ill, however, is limited to the amount incurred for qualified long-term care expenses up to $240 per day in 2005 (adjusted annually for inflation).\textsuperscript{41} Any amounts received that exceed this limit must be included in gross income. Even if the ADBs are not excluded from gross income, a chronically ill person may have offsetting (in full or in part) medical expense deductions for qualified long-term care services to the extent these (with other medical expenses) exceed 7.5 percent of adjusted gross income.\textsuperscript{42} The exclusion of ADBs from gross income does not apply if the insured is a director, officer, or employee of the

\textsuperscript{38} See e.g., Virginia Administrative Code § 14VAC5-70-70 (2003).

\textsuperscript{39} See e.g., Virginia Administrative Code § 14 VAC5-70-80 (2003).

\textsuperscript{40} IRC § 101(g)(1)(A) (2004).

\textsuperscript{41} IRC § 101(g)(3) (2004) provides that the exclusion from gross income for a chronically ill individual will not apply to any payment received for any period unless (i) such payment is for cost incurred by the payee (not compensated for by insurance or otherwise) for qualified long-term care services provided for the insured for such period and (ii) the terms of the contract meet certain requirements. The payment may be made on a per diem or other periodic basis without regard to expenses incurred during the period to which the payment relates.

\textsuperscript{42} IRC § 213 (2004).
taxpayer receiving the accelerated benefit, or if the insured has a financial interest in a business conducted by the taxpayer. For example, the exclusion would not apply where a company owns a life insurance policy on the life of a terminally ill officer or employee.

III. USING HOSPICE TO AVOID INAPPROPRIATELY AGGRESSIVE CARE DURING A TERMINAL ILLNESS

Clients frequently seek our advice about how to avoid inappropriately aggressive healthcare. The Medicare Hospice Benefit is one option that is often underutilized. In Virginia and New Jersey, only 18 percent and 19 percent, respectively, of Medicare patients used hospice during the last year of life. Since most of our clients do not want aggressive care during a terminal illness and hospice usage rates are so low, we believe that there is a need for Elder Law attorneys to educate their clients about this option.

Hospice care provides for management and palliation of terminal illness, as opposed to curative treatment of the underlying terminal illness or injury. The service must be provided by a Medicare-certified hospice provider. Care can be provided in the home (including a nursing home or assisted living facility) or in a freestanding hospice. The Medicare beneficiary, or an authorized representative, must specifically elect to receive hospice care and has the power to revoke the election at any time. The election is filed with the hospice that will provide the care.

The representative must have authorization under state law to make such elections, for hospice care, either under an advance medical directive, or as guardian for the beneficiary. The hospice physician and the beneficiary’s attending physician must certify in writing that the beneficiary is terminally ill, with a good-faith medical prognosis indicating that the beneficiary’s life expectancy is six months or less if the terminal illness runs its normal course. The certification is filed with the hospice provider that will be providing the care. The beneficiary does not have to be home-bound or have a “do not resuscitate order” to qualify for Medicare hospice care.

The Medicare hospice benefit consists of two separate periods of ninety (90) days. After the initial two 90-day periods, the benefit provides an unlimited number of

43. IRC § 101(g)(5) (2004).
49. 42 C.F.R. § 418.22 (2004). HCFA Program Memorandum, Transmittal AB-01-99 states that this six month certification is based on clinical judgment regarding the normal course of illness and recognizes that making estimates of life expectancy is not always exact.
subsequent periods of sixty (60) days each. At the end of each benefit period, if the beneficiary has not revoked the election, one physician (either the attending physician or the hospice physician) must certify in writing that the beneficiary is still terminally ill. If the beneficiary lives beyond six months, the beneficiary’s benefits continue so long as the initial life expectancy certification was made in good faith. While the beneficiary is receiving hospice benefits, Medicare will not pay for treatment to cure the underlying terminal illness or injury, but will continue to pay for treatment for illnesses or injuries unrelated to the terminal condition. If the beneficiary later revokes the hospice election, Medicare will once pay for treatment related to the terminal condition. The beneficiary can change the hospice that is providing care; this does not serve as a revocation of the election. This can be done once during each benefit period by providing written notice to both the current hospice and the new hospice. A beneficiary who wants to change hospice providers more than once during a benefit period, must revoke the hospice election and re-elect the benefit in a new election period.

The Medicare hospice benefit provides a wide variety of services, including: nursing care, medical social services, physician’s services, counseling services for the beneficiary and the beneficiary’s family, short-term inpatient care, respite care, medical appliances and supplies, drugs and biologicals, home health aide services, homemaker services, and therapies including physical, occupational, and speech-language pathology. The hospice’s interdisciplinary group must provide a written plan of care that must include information regarding detail the beneficiary’s needs, and the services to be provided, including the scope and frequency of such services, and the drugs and biologicals that will be administered to the beneficiary. Drugs and biologicals have a co-payment requirement but other hospice services do not. Because hospice care can be provided in a skilled nursing facility, beneficiaries should inquire about the availability of hospice services when selecting a nursing facility.

IV. OBTAINING OR REFUSING TREATMENTS THAT REFLECT THE CLIENT’S WISHES

Most older clients have to confront the necessity of making critical health care decisions. Many of them have treatment preferences and wish to avoid inappropriately aggressive healthcare during a terminal illness. How should these treatment preferences and wishes be implemented if the client is unable to make his or her own health care decisions? Unfortunately, our older clients must comply with a complex set of court decisions and laws to answer this question. Elder Law attorneys are uniquely qualified to assist their older clients and their families when confronted with this difficult situation. In 1990, the United States Supreme Court held in *Cruzan* that the Fourteenth Amendment protects a person’s “liberty interest in refusing unwanted medical

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treatment." This right to make medical treatment decisions has, however, been limited by countervailing state interests, such as 1) protecting a minor child; 2) considering the interests of innocent third parties; 3) preserving life; and 4) maintaining the ethical integrity of the medical profession. Most state courts have a significant line of cases that deal with the standards for health care decision-making involving an incapacitated patient. The courts acknowledge that incompetent persons have the same rights as competent ones, even if a surrogate must exercise their rights. Because of the involvement of the surrogate, the Court in *Cruzan* held that states may establish procedural safeguards to protect the rights of incompetent persons, and doing so does not violate the Fourteen Amendment.

In January 2005, the procedural requirements for surrogate health care decision-making were once again presented to the United States Supreme Court in *Bush v. Schiavo*. The case revolved around Terri Schiavo, a young woman who suffered severe brain damage in 1990 that left her in a persistent vegetative state. Schiavo had not left written instructions on how to manage her health care if she became incapacitated. In 1993, after three years of aggressive treatment, her parents and spouse disagreed on whether to remove her feeding tube. Schiavo’s husband, as her guardian, was authorized to remove the feeding tube in 1993. However, her parents initiated a series of unsuccessful legal actions to challenge to the husband’s right to do so. What made the case remarkable was the subsequent executive and legislative branch interventions at the parents’ request. Later, the governor of Florida intervened to “protect vigorously the rights of people who cannot speak for themselves.” Without comment, the court ended the Governor of Florida’s challenge to a Florida Supreme Court decision striking down a law that let the Governor order the reinstatement of Terri Schiavo’s feeding tube. Thereafter, the United States Congress and the President granted the Federal Courts jurisdiction to review the withholding of food and fluids from Terri Schiavo. The United States District Court, Eleventh Circuit Court of Appeals and the United States Supreme Court denied Terri Schiavo’s parents’ motion for a Temporary Restraining Order to require that her feeding tube be reinserted. Fifteen years after suffering severe brain damage and 13 days after the removal of her feeding tube, Terri passed away on March 31, 2005. The case demonstrates the importance of setting out treatment wishes in a written advance directive and discussing these wishes with the family.

Another controversy has arisen concerning the right of patients to obtain physician assistance in dying. An Oregon statute became effective in 1997 allowing a physician to assist a terminally ill patients in their death. Since the statute became effective, over 170 terminally ill persons have elected to die with the help of a physician.

Oregon’s statute was upheld by the United States District Court for the District of Oregon and the United States Court of Appeals for the Ninth Circuit. On November 9, 2004, the Attorney General appealed these decisions to the United States Supreme Court. The United States Supreme Court granted certiorari, and the case will be heard by the Court in its September 2005 term.

The lesson from Schiavo is that one should be prudent when naming who is to make another’s end-of-life decisions. There are two familiar documents: a surrogate health care form and a living will. While a surrogate health care decision-maker can be a court-appointed guardian, an individual is far better served by executing an advance directive in the form of a living will, medical power of attorney or a combination of both. A living will is an expression of how the client wants to be treated during end of life care, or when recovery is no longer possible. A medical power of attorney is a delegation of authority to a third party to make health care decisions for the client. All fifty states, including the District of Columbia, permit the execution of these documents.

Should the client use a medical power of attorney or living will? Some claim that the use of living wills should be avoided because clients lack the knowledge to make intelligent decisions in advance, and so their preferences are not adequately articulated. Others note that too often, third parties do not accept living wills. For our older clients who know about their existing health conditions and have strong preferences about their treatment, we recommend a combination of a living will and medical power of attorney. The living will states the client’s preferences, while the medical power of attorney authorizes the agent to implement those preferences. For those clients who do not know about existing conditions or treatment preferences, a medical power of attorney may be sufficient.

When drafting an advance directive, the Elder Law attorney should start with the state statutory form, where available, because it will be recognized by health-care providers. They can then customize the statutory form to address the client’s particular concerns by assisting the client to focus on questions such as:

- Who do you want to will serve as the health care agent and alternative agent?
- If co-agents are appointed, must they act jointly or may they act independently?
- Whether the client has identified anyone who does not share the client’s values, and who the client wishes to expressly deny any authority to make health care decisions for them?

58. See e.g., Virginia Code §54.1-2981 et. seq. (2003).
60. Virginia Code § 54.1-2984 (2004) contains the Virginia statutory advance directive form. See Appendix A for a copy of the Advanced Directive form used by Oast & Hook, which is based on the Virginia statutory advance directive. It is important to note, however, that not every state has a statutory advance directive form. For example, New Jersey does not have this form.
• Under what conditions, if any, does the client want to authorize the withdrawal of life sustaining medical treatment, including artificial nourishment or hydration?
• Does the client have a known physical ailment that should be described along with the treatments that he or she wants to reject?
• Does the client have any specific preferences concerning health care facilities or providers?
• Does the client have any moral or religious convictions that dictate use or rejection of specific certain forms of medical treatments?
• Does the client want to make anatomical gifts or give the agent the power and authority to make these gifts?
• Does the client want to authorize the agent to determine who may visit?
• Does the client wish to obtain physician assistance with dying, to the extent compatible with state law?

In light of the privacy rules in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations, the advance directive should include a specific, immediate authorization under HIPAA, for the client’s health care agent to obtain confidential information concerning the client’s mental and physical condition.

The Elder Law attorney should discuss with the client how to make the existence of the advance directive known to the client’s family and physicians. At a minimum, clients should have a candid and frank discussion of the advance directive and their care preferences with their immediate family, the health care agent and primary care physician and provide all of them with copies of all health care documents. To assist the older client in initiating this discussion, the attorney can offer to mail copies of the advance directive to the client’s family, physician and health care agent. Where the client is having a difficult time discussing his care with his or her family, the attorney may wish to loan the client a copy of the Long Good Bye: The Deaths of Nancy Cruzan. The book is an excellent tool to demonstrate the importance of having an advance directive and will facilitate intra-family discussions of the client’s wishes.

Some attorneys provide their clients with a laminated wallet card that advises third parties of the existence of the advance directive and the names and phone num-

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63. “Family members also play a major role in influencing the decisions of doctors. In a study released in July, researchers found that 65 percent of 117 southern California doctors surveyed chose to ignore advance directives when asked to consider the hypothetical cases of six unconscious patients. Many of the doctors were swayed by the contrary wishes of the patient’s imaginary ‘relatives.’ Other studies have reported similar findings. Indeed, hospitals worry more about lawsuits by family members than by patients who are hardly in the condition to sue, says Dr. Brody.” The Christian Science Monitor, Living Wills May Require Extra Steps to Be Binding http://www.csmonitor.com/2004/0929/p14s03-usju.html (September 29, 2004).
64. Written by William H. Colby, the attorney who represented Nancy Cruzan’s parents, and published by Hay House in 2003.
bers of the client’s health care agents. The attorney may also want to advise the client about commercial advance directive registries that will store the client’s advance directive and, if the client is hospitalized, fax a copy of the advance directive to the hospital.  

5. MINIMIZE FINANCIAL BURDENS AND MAXIMIZE FINANCIAL OPPORTUNITIES

The management of an of a client’s financial affairs is often complex, even aside from periods of disability, when the client is dependent upon others for assistance. The client’s family and fiduciaries (guardian under durable power of attorney or trustee under a revocable trust) must monitor the investment of the client’s assets and manage the clients personal and business affairs. The Elder Law attorney should offer the client’s family or fiduciaries assistance in developing and implementing appropriate investment and personal financial assistance plans.

A. Investment Advice

Our clients have spent a lifetime accumulating assets. As a result, frequently, the client will have many investments and investment accounts, including IRAs and 401(k) accounts. Some obtain investment advice from agents at several broker/dealers with fees based on commissions, while others make their own investment decisions using discount broker/dealers or no-load mutual funds. Some are overly cautious, investing in only in certificates of deposit or money market accounts. Others are overly aggressive, fail to diversify, take inappropriate risks, or make illiquid investments. If the Bush administration proposal to privatize Social Security passes and workers invest a portion of their Social Security contributions, clients will have even greater investment management responsibility. Unfortunately, many of our clients will be mentally or physically unable to assume this responsibility.

Although confronted with the necessity of managing investments such as IRA’s and 401(k) accounts to provide for their retirement and long-term care, most clients have not created a formal investment plan, committed it to writing, or regularly reviewed and monitored their investments. As a result, they often invade capital to pay significant expenses for their long-term care. Many times, this causes their standard of living—or their family’s inheritance—to be in jeopardy. Frequently, the client’s agent, trustee, or executor—who in many cases is a family member or friend—has a similar lack of knowledge and education about investment planning. Yet, they have fiduciary duties under applicable state law, including the Uniform Prudent Investor Act (UPIA), to manage the client’s investments appropriately. Their failure to develop and im-

65. See e.g., www.uslivingwillregistry.com and www.docubank.com. A five-year subscription to one of these services will typically cost the client about $90 for an individual or $180 for a couple. As part of the estate planning services provided by the attorney, some members of the NAELA are obtaining discounts for these services through the NAELA Affinity Program and providing their Older Clients with a subscription to one of these services.

66. These duties include the duty to know standards, laws and trust provisions: to avoid conflicts of interest and prohibited transactions; to diversify assets and investments to the client’s risk/return profile; to prepare an investment policy statement and document due diligence; to use prudent ex-
implement an appropriate investment plan will frequently result in inaction, or rush action, additional higher expenses, mistakes, poor investment results, lower returns and potential personal liability. Consequently, there is an opportunity for the Elder Law attorney to provide education, guidance and advice to their clients and their fiduciaries concerning a prudent investment management practice process.

Do legal ethics prohibit an attorney from acting as an investment advisor to his or her clients? Generally, an attorney may act as an investment advisor for his or her clients provided that the rules of Professional Conduct are strictly followed.67 An attorney does not have to register as an investment advisor (RIA) under the federal Investment Adviser’s Act (15 USCS §80b-2(a)(11)) or the model Uniform Securities Act (enacted by Virginia at Virginia Code §13.1-501 A) if he or she 1) does not hold himself or herself out to the public as providing investment advisory services; 2) does not charge a separate fee in addition to routine charges for incidental advice provided; and 3) the advisory services are reasonably related to his or her professional services. However, an attorney who holds him or herself out as an investment advisor or charges a separate fee for investment advice, should register as an RIA and obtain an appropriate license as a “Registered Investment Advisor Representative” (Series 65 exam).68 An attorney who forms a company to serve as an RIA must decide whether to operate it independently or form an alliance with an established RIA and act as a solicitor for it.69

Attorneys considering becoming investment advisors should consider additional training. For example, the Center for Fiduciary Studies (Center) at the University of Pittsburgh trains professionals to understand the intersection between their professional responsibilities and the investment process. The program provides a comprehensive overview of fiduciary standards of care, asset allocation, preparation of investment policy statements (IPS), manager search and due diligence, performance measurement, and other related subjects. The program prepares the studies for designation as an accredited Investment Fiduciary (AIF) or Accredited Investment Fiduciary

67. Connecticut Bar Association Inf.. Op. 89-10 (March 1, 1989) (Lawyers as Investment Advisors). However, the Maryland Bar Association Ethics Committee has ruled that an attorney may not conduct a dual practice of law and investment advisory. Maryland Bar Journal (May/June 2004).

68. The Virginia State Bar advises has opined that an attorney/draftsman who contemplates charging separate fees for investment Opinion 1515, tax or other services, over and above the fees for executor/trustee, must also fully disclose those separate fees.

The Center has developed twenty-seven practice standards to assist in the implementation of a formal investment plan that will comply with the provisions of the Uniform Prudent Investor Act (UPIA) and ERISA (Employee Retirement Income Security Act).

Training for investment advisors stresses the importance of counseling clients or their fiduciaries to implement a formal investment plan, including an IPS, and to document implementation and monitoring of the plan. The plan should be implemented by following a five-step process:

1. Analyze the client’s current investments,
2. Develop an appropriate asset allocation,
3. Develop and commit an investment planning to writing in the form of an Investment Policy Statement,
4. Implement the plan, and
5. Monitor the plan.

The Elder Law attorney should encourage the client or the client’s fiduciaries to obtain the assistance of an AIF or AIFA to prepare and implement an IPS, which should include:

- The client’s investment objectives.
- A statement of investment objectives including levels of acceptable risk, expected time frame, and rates of return objectives.
- The duties and responsibilities of the investment advisor, money manager, custodian and client.
- Provide guidelines for selection of investments and the money manager.
- Provide for required reporting by the money manager and a schedule for performance review, and
- Provide for a considerations and guidelines to be employed when replacing the money manager.

70. These designees must be able to demonstrate that they understand and can articulate the legal and regulatory environment surrounding a fiduciary with investment responsibility, be able to develop and implement an effective investment management process applying the principles of Modern Portfolio Theory, document all due diligence, and above all, treat their clients with the utmost prudence and care.


72. A list of Accredited Investment Fiduciaries and Accredited Investment Fiduciary Auditors may be found at www.cfstudies.com.

73. The money manager should on a monthly basis provide a report including: 1) a list of current holdings, 2) a comparison of the asset allocation to the target allocation, 3) trading costs and custodial transactions, 4) comparison of investment performance to benchmark, and 5) evidence that the money manager is seeking “best execution” and abiding by soft dollar guidelines. Performance should be reviewed at least quarterly and investment objectives should be reviewed at least annually.
B. Personal Financial Assistance

Clients who suffer from chronic illnesses often find it difficult to manage their affairs. They require assistance with bill paying, tax planning and return preparation, management of investments, arranging for care in the home or a facility, funeral planning, and obtaining necessary healthcare. They also may require assistance with health or long-term care insurance claims. They must deal with complex tax rules, such as the rules relating to the taxation of Social Security benefits, the deduction of medical and long term care expenses, the exemption from taxation of the proceeds of the sale of a principal residence, and the minimum distribution rules for qualified retirement plan accounts and IRA’s. They must also consider reallocating investments to pay for needed services and care, such as a move to an assisted living facility, continuing care retirement community or nursing home. In-home care agencies and long-term facilities will have contractual agreements that the client must review and execute. The Elder Law attorney should assist the client in establishing a mechanism to provide or obtain the delivery of necessary services and assistance. We call this mechanism a “Family Office,” which can ease the financial and planning burdens faced by our Older Clients and their families.

How should the Personal Financial Assistance be structured? We recommend the use of a financial power of attorney and/or a revocable living trust. When providing Personal Financial Assistance, the most important decisions to be made are who should be appointed Fiduciary and what oversight should be required. We frequently recommend the use of co-agents or co-trustees to provide a “second set of eyes” and to avoid creating an “empowered” family member.

The power of attorney and any trust agreement should be customized to provide the specific authority required to:

- Provide services needed by the client;
- Provide guidance concerning the clients’ preferences in the delivery of these services;
- Support the client’s spouse or other dependents;
- Continue the client’s history of charitable or family gifts;
- Permit the trustee or agent to liberally invade principal for the benefit of the client and treat the rights of remainder beneficiaries as matters of secondary importance;
- Direct the trustee or agent to make every reasonable effort to involve the client in decision-making regarding both financial matters and personal care;
- Set out the terms of compensation for the agent or trustee;
- Waive the prohibitions against self dealing, where a family member is serving as trustee or agent, provided that the terms of the transaction are fair to the client; and
- Provide a mechanism by which the agent or trustee must “account” to the client or to a third party if the client is incapacitated.

Though a spouse or child is the logical person to provide the personal financial assistance services. Many of our clients are widows or widowers and some do not have
any children upon which they can rely. The children of other clients will be scattered around the country. Some children will be unable to provide these services due to commitments to their families or at work. In other cases the family may not be the logical choice due to multiple family groups resulting from second marriages or differences of opinion. In these cases, a professional fiduciary should be considered.

As part of their service as a Family Office, many Elder Law firms are serving as fiduciaries (as agent under power of attorney, or, trustee, executor and guardian/conservator) to provide Family Office services to their clients. Prior to undertaking to provide these services, the Elder Law attorney should first build the infrastructure in the firm to insure the delivery of quality services.

Additionally, prior to undertaking to provide these services, the attorney should insure compliance with applicable legal ethics rules and obtain adequate malpractice insurance and fidelity bonds. In our respective firms, we have hired paralegals, accountants and geriatric care managers to assist in delivering and or supervising the delivery of these services. Some services for our client’s are outsourced to other professionals or firms such as the delivery of in-home care or custody of client assets. We have also obtained the AIF designation to obtain training in the management of the investment of our client’s funds.

VI. USING AN ETHICAL WILL TO ASSIST IN ALLEVIATING GRIEF

Frequently, our clients have “legacies” that they want to pass on to their families. These legacies are not necessarily comprised of financial or other monetary assets but instead contain important information, values, hopes or family history that they want saved for future generations. The sharing of this information can ease both the client and his or her family’s bereavement. Therefore, the Elder Law attorney should encourage the client to write a personal message, sometimes called an “ethical will” to his or her family to provide this information and to transit this legacy. Ethical wills frequently include a family history or tree; personal hopes, values and beliefs; forgiving others or asking forgiveness; and explanations for decisions made during life.

An ethical will is not a legal document, but a personal letter or message from the client to his or her family. It can be in the form of a written letter or an audio recording. While it is not a legal document, for many clients it is a valuable addition to the estate plan. The Elder Law attorney should raise the option of preparing the client’s ethical will and should keep it with the client’s legal will. The Elder Law attorney can provide the client with a template to use in preparing the ethical will and include a section in the binder of estate planning documents to hold it. As an alternative, some NAELA members are purchasing ethical will kits through the

74. See e.g., Virginia Legal Ethics Opinions 1515, 1754 (2002).
75. Since the codes of professional responsibility for most states prohibit an attorney from sharing legal fees with a non-lawyer or forming a legal partnership or professional corporation with a non-lawyer, an Elder Law firm should retain these allied professionals as common law employees. See Rule 5.4 of the Model Rules of Professional Conduct.
76. See www.ethicalwill.com for a variety of sample ethical wills.
NAELA Affinity Program to distribute to their Older Clients as part of the attorney’s services.77

VII. SELF-SETTLED SPECIAL NEEDS TRUSTS

Estate Planning and Elder Law Attorneys are frequently asked to draft third party special needs trusts to protect a gift to a disabled family member. However, few have drafted a self-settled special needs trusts. These trusts are critical for clients receiving means-tested certain public benefits such as SSI, Medicaid and Section 8 Housing.

Although self-settled special needs trusts are similar to a third party special supplemental needs trust with respect to the issue of availability, the law concerning transfer penalties and Medicaid payback are completely different. The rules pertaining to these trusts are spelled out in the Social Security Administration Program Operating Manuals (The POMs) which are available online.78 The POMs are issued by the National Social Security Office in Baltimore, but there are also regional POMs issued by the various regional SSA offices. Because regional POMs often rely on the various state laws to reach their conclusions, the regional POMs differ in certain regions and states. In addition, State Medicaid Agencies have begun to render their own interpretations of the requirements that impose additional limitations which are not always consistent with the POMs. Whether State Medicaid Agencies have the authority to issue interpretations conflicting with the POMs is an issue currently being litigated around the country.79

Merely drafting self-settled, special needs trusts by themselves is not a successful practice model. Rather, the Elder Law attorney should provide full service support to personal injury and family attorneys who have clients with disabilities, including:

- Assisting with the settlement of Medicaid and Medicare liens;
- Advising on the tax consequences of the trust and proposed settlement terms;
- Advising on the need for “structuring” a portion of a personal injury settlement or award;
- Educating the disabled client and the client’s family concerning available benefits;
- Drafting the trust agreement;
- Drafting petitions and appearing in court to obtain court approval of the trust;
- Reporting the creation of the trust to the Social Security Administration and state Medicaid agency;

77. See e.g., www.americaslifestories.com for an example of such a kit.
79. For more in drafting issues on Self-Settled Special Needs Trusts, see Thomas D. Begley, Jr. and Andrew H. Hook, Drafting Issues in Self-Settled Special Needs Trusts Estate Planning Magazine (October 2004).
• Helping prepare applications for Medicaid, SSI, Medicare, COBRA health insurance benefits or other public or private insurance benefits;
• Assisting with the establishment and administration of the trust, including preparation of inventories, accountings and tax returns; and
• Preparing estate plans and related documents for disabled adult competent clients.

VIII. SERVING AS A FIDUCIARY

Clients often choose family members as agents, executors or trustees; in part because they know and trust them. A family member, however, may not be a wise choice. A fiduciary has duties imposed by the Prudent Investor Act, Principle and Income Act, Internal Revenue Code, Probate Code, Trust Code and other applicable laws and regulations. Few family members have any familiarity with the obligations imposed upon a fiduciary. Moreover, many families are dysfunctional, or family members have conflicts of interest, with the result that the selection of a family member as a fiduciary may lead to controversy or litigation. Other clients have no immediate or available family members who can serve as a fiduciary. A particularly troublesome fiduciary position is that of a trustee of a third party supplemental needs trust or Special Needs Trust. In these situations, the trustee must also be familiar with various public benefits laws that may affect the trust beneficiary.

The best solution in all of these situations is to engage a professional trustee. In recent years, however, many professional trustees have increased the minimum accounts that they are willing to serve to a million dollars or more so that many clients cannot engage a professional trustee. The attorney can provide a valuable client service by filling this void by serving as a fiduciary. To provide this service, an Elder Law attorney should develop a business plan, build the necessary infrastructure (including education, equipment and staffing), and obtain appropriate bonds and malpractice insurance. Most attorneys are not comfortable in managing investments, but under the Prudent Investor Act, this duty can be delegated after proper due diligence. Attorneys interested in serving as trustee would be well advised to take a course such as that offered by The Center for Fiduciary Studies at the University of Pittsburgh Graduate School of Business.

IX. FIDUCIARY LITIGATION AND DISPUTE RESOLUTION

Elder Law firms have traditionally featured a transactional legal practice. However, many clients and their families require assistance to avoid potential disputes, resolve existing disputes or petition a court for judicial relief. These cases frequently arise from the failure of the family communication, poor or no planning or dysfunctional family groups. To assist in resolving potential or existing disputes, the Elder

80. For additional information concerning establishing a fiduciary practice in a law firm, see Guide for ACTEC Fellows Serving as a Trustee (American College of Trust and Estate Counsel, December 6, 2000).
Law attorney may facilitate family meetings or provide mediation services. In other cases, the Elder Law attorneys will counsel the client and the family about:

- Converting an income only trust to a unitrust;
- Probating a lost will;
- Contesting the probate of a will;
- Petitioning a court for the appointment of a guardian or conservator;
- Petitioning a court for the construction of a will or trust;
- Petitioning a court for an accounting and sanctions against a fiduciary for mismanagement of an estate or trust;
- Petitioning a court for the appointment of a successor fiduciary;
- Appealing a government agency denial of an application for public benefits;
- Seeking damages for elder abuse or nursing home torts;
- Petitioning a court for the creation of a Special Needs Trust; and
- Petitioning a court to determine the amount of a surviving spouse’s share of the deceased spouse’s augmented estate.

To provide complete service, Elder Law attorneys should consider adding alternative dispute resolution (including family meetings, mediation and arbitration) and trial practice to their service mix. An Elder Law attorney who does not wish to personally provide these services, should consider forming an alliance with a competent mediator or trial practice and serving as co-counsel or, where permitted by ethical rules, referring the case for a referral fee.81

X. PROVIDING INSURANCE PRODUCTS

Frequently, attorneys will recommend that their clients purchase insurance to implement estate and long-term care plans. In states where lawyers are permitted to provide ancillary business services under the state’s version of ABA Model Rule 5.7, the lawyer should consider becoming licensed to do so. There are a number of situations that commonly arise, in which the lawyer can provide a needed service by providing the insurance product.

The following are examples of common situations where attorneys recommend insurance products:

- Many Elder Law firms recommend that healthy clients purchase long term care insurance. Though clients may see the value in this advice, they seldom follow through and actually obtain the insurance. If the lawyer was licensed to sell insurance and could take an application on the spot, it is likely that many more people would be covered with long term

81. See e.g., Rule 1.5 (e) of the Virginia Rules of Professional Conduct which permits the division of a fee between lawyers who are not of the same firm if: (1) the client consents (2) the terms of the division are disclosed to the client, (3) the total fee is reasonable, and (4) the client’s consent is obtained before the rendition of services. However, Rule 1.5 (e) of the ABA Model Rules of Professional Conduct additionally requires that the division of attorney’s fees be in proportion to the services performed by each lawyer or each lawyer assumes joint responsibility for the representation.
care insurance. In order to protect the lawyer’s independent judgment, the law firm should develop criteria for when coverage is appropriate. For example, from an asset standpoint, the criteria might be that the person own a home and have $200,000 of liquid assets. From an income standpoint, the criteria might be that the long term care insurance premium not exceed ten percent of the client’s gross income.

- Lawyers frequently have estate planning clients who need a life insurance policy to pay debts, support dependents or death taxes. Typically lawyers refer the insurance to a life insurance agent, but the client may be better served by purchasing the insurance from the lawyer who developed the plan. Here again, the law firm should develop criteria for how much insurance is required and adhere to these criteria.

- Most married couples want to divide their estates equally among their children after the death of the survivor. This is true even if one of the children is disabled. If a family has three children, two of whom are healthy and can work, and one of whom is disabled and will never be able to work, equal distribution makes no sense. The lawyer should encourage the parents to determine what amount of money will be required to provide the disabled child with an appropriate life style. This can be done by obtaining the services of a life care planner, by using the Merrill Lynch calculator on the Merrill Lynch website\(^\text{82}\) or by having the parents develop a budget, making an annual calculation and building in an inflation factor. Once this exercise is complete, it will become obvious to the parents that the disabled child needs far more than the healthy children. The best solution is often for the parents to purchase a second to die life insurance policy. The policy can be owned by an Irrevocable Life Insurance Trust with special needs provisions. The attorney would then provide not only the plan, the legal advice and the documents but also the insurance product.

- In light of the income-first method\(^\text{83}\) used by many states in determining Medicaid eligibility for long term care assistance, many Elder Law attorneys recommend that community spouses purchase a Single Premium Immediate Annuity (SPIA) to provide the spouse with additional income with excess resources. The attorney developing the plan and who is familiar with the state’s Medicaid rules relating to annuities will


\(^{83}\) In Wisconsin Dep’t of Health & Family Servs. v. Blumer, 122 S. Ct. 962 (2002), the U.S. Supreme Court held that a state’s use of an income-first method to bring a community spouse’s income up to the MMMNA did not conflict with the Medicare statute. The Court found that income-first is an acceptable interpretation of the Medicaid Act. In its opinion, the Court noted the efforts of CMS to clear up the issue through administrative procedures and, more recently, the issuance of a rule that allows states the choice of using either the income-first or the resources-first method. The majority of states have adopted the income-first rule.
miliar with the state’s Medicaid rules relating to annuities will frequently be in the best position to provide the appropriate SPIA.

In all situations where the attorney is going to sell the client insurance, the first step is to consult state ethics rules and opinions to determine if the attorney is permitted to do so. Next the attorney needs to be licensed, which usually requires a course of study and passing an exam.

XI. PROVIDING INVESTMENT PRODUCTS

Previously in this article, we recommended that Elder Law attorneys consider offering investment advice to their clients. Some attorneys may wish to sell investment products such as stocks, bonds, variable annuities, and mutual funds to assist their clients in implementing their advice. Why? Our clients, particularly middle class clients, often come to us for Medicaid or estate planning and it immediately becomes obvious that the client has no investment plan. The client may have old government bonds, which have accumulated interest for many years and may have even stopped paying interest. Some have been victims of unscrupulous investment advisors who have churned their accounts, or they have been victims of unscrupulous financial advisors who have sold them inappropriate annuities. A lawyer can assist clients in developing a financial plan, or an Investment Policy Statement. After assisting with the development of the investment plan, the attorney is in the best position to assist the client in obtaining the financial products that are appropriate to implement the plan. In order to provide these products, the lawyer must consult state ethics rules to determine if a lawyer is permitted to provide ancillary business services and if so, do these services fall within the definition of ancillary services. The lawyer must also obtain the necessary securities licenses and should consider forming an alliance with an established RIA.

Some lawyers are reluctant to embark on this course of action feeling that they would be sacrificing their independent judgment. Yet the client has confidence in the lawyer and has often been ill served by a previous financial advisor. The client would be far better off buying products from his or her attorney.

84. In Virginia, an attorney who is licensed to sell insurance may receive commissions for the sale of insurance to a client after full and adequate disclosure to the client and provided that the transaction is fair and reasonable to the client. Virginia Legal Ethics Opinion 1754. See also New Hampshire Bar Association Ethics Committee Formal Opinion #1998-99/14 that states: “A lawyer may sell life insurance to her clients provided she complies with Rules 1.7(b) and 1.8(a): 1) The transaction and terms must be fair and reasonable to the client, and 2) The lawyer must believe the representation will not be adversely affected.” These opinions are in conformity with the District of Columbia Bar (Ethics Opinion 306); New Hampshire Bar (N.H. Bar Op. 1998-99/14), South Carolina Bar (S.C. Adv. Op. No. 98-29), Utah Bar (Utah Eth. Op. No. 146A), Michigan Bar (Mi. Eth. Op. No. RI-135), and Illinois Bar (Ill. Adv. Op. No. 90-32).

85. An attorney who intends to sell mutual funds, variable insurance products, stocks, and bonds, must obtain additional licenses. The Investment Company and Variable Products license (Series 6 exam) will permit the attorney to sell mutual funds and variable insurance products. The General Securities license (Series 7 exam) will permit the attorney to sell stocks and bonds.
XII. REAL ESTATE COMMISSION REFERRAL FEES

Many of our clients must sell their homes and move to a smaller home, assisted living facility, continuing care retirement community or nursing home. Other times, their executor must sell the client’s last residence. These are very stressful occurrences. When assisting with Medicaid planning, estate planning or conservatorship/estate/trust administration, we are frequently asked to refer the client or the client’s family to a realtor to sell the client’s home. Provided that the attorney is licensed as a realtor and after complying with applicable legal ethics rules (i.e. typically obtaining the client’s consent after full disclosure) the attorney may receive a referral fee from the realtor upon the sale of the property. Referral fees are typically 20 percent to 30 percent of the gross commission.

XIII. CONCLUSION

To be successful, Elder Law attorneys must accept that 1) changes to laws and rules have and will impact their firms, 2) their client’s expectations and needs are changing and 3) new forms of delivery of necessary professional services are evolving. In light of these structural changes in the market place, merely maintaining the status quo is not a business model for a successful Elder Law practice. While change is not easy, successful firms will embrace this change and promptly adapt their practices to these changes. To assist the members of our firms, we purchased a copy of “Who Moved My Cheese?”86 for each staff member and had firm wide discussions about the changing environment that our firms were confronting and how to adapt our firms to this new and constantly, evolving environment.

What is the current business environment confronting Elder Law firms? From our experience, Elder Law firms are frequently small, undercapitalized practices. They tend to react rather than anticipate changes in the business environment. Although they tend to be risk adverse, they are facing numerous risks, including regulatory, market and business risks, including:

- Changes to wealth transfer taxation rules and Medicaid long-term care eligibility rules that will diminish the value of some services traditionally provided by Elder Law practices.
- Market risks including increased competition for provision of routine legal information and documents from many new sources including document assembly software, consumer books, the Internet, foreign lawyers and non-lawyers including legal document preparers, accountants, financial planners, and financial service firms. Because the public perceives the value of this information and service, the competition will not be stopped by unauthorized practice of law rules.

• The business risks include the failure to prepare and implement a business plan that anticipates changes in the marketplace rather than merely reacting after changes have occurred. Being small businesspersons involved in their day-to-day practices, many Elder Law attorneys frequently ask “What happened?” rather than “What is likely to happen and how should we plan to be well positioned for this anticipated change?”

How should the Elder Law firm respond to these risks and our new business reality? We believe that the best response is to adopt and implement a business plan for the firm to provide holistic and complete solutions, incorporating legal, accounting, care management, tax return preparation, fiduciary, insurance and investment services, to address our Older Clients’ unmet, pressing needs. In other words, we recommend that Elder Law firms expand the services provided to their existing client base, rather than merely continue to “market” their traditional services to new clients. We believe that the provision of new value-added services that help our existing clients will result in our satisfied clients referring new clients to us. Some firms will choose to pick among the services discussed above. Others will choose to provide all or most of them. In order to provide complete solutions to client problems, we recommend the latter course.

To provide these new services, Elder Law attorneys will have to invest significant amounts of their time and money in expanding the size of their staffs and obtaining additional education. Some Elder Law attorneys will obtain insurance licenses so they may sell life, health and long term care insurance. Still others will obtain securities licenses and form Registered Investment Advisor (RIA) firms to provide investment services. Other Elder Law firms will provide multi-disciplinary services by hiring nurses, geriatric care managers, social workers, financial planners and accountants. These actions require advance planning and must be implemented in a thoughtful manner to insure that the attorney complies with all ethical and legal requirements necessary to provide these new services to protect the client’s interests.

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87. Paragraph H, entitled Ancillary Services, of the Aspirational Standards for the Practice of Elder Law, adopted by the NAELA Aspirational Standards provides in part: “The complex problems faced by elders . . . involve more than legal issues. Some elder law attorneys offer ancillary services such as insurance and annuity sales, care management, tax preparation, and fiduciary or investment services, as allowed by those states that have adopted a rule such as 5.7. Clients may find it convenient and reassuring to put their trust in one source to meet a variety of needs.”

88. While we do not believe that marketing is the answer by itself, we believe marketing is important for Elder Law firms. We recommend that Elder Law firms retain a professional marketing firm for assistance and devote from 5 percent to 10 percent of gross revenues to marketing.

89. For example, the NAELA Aspirational Standards require that an Elder Law attorney who provides ancillary services to: 1) be competent and appropriately licensed, 2) provide ancillary services that meet the needs of the client, 3) disclose to the client all relevant matters concerning the ancillary services, 4) obtain the client’s prior written consent before providing ancillary services, and 5) protect the client’s confidences and avoid conflicts of interests. Virginia, while not having adopted ABA Rule 5.7, appears to have approved the concept that a lawyer may provide ancillary business services to clients provided the following requirements are met: 1) full disclosure (Rule 1.7), 2) the transaction must be fair and reasonable to the client and the client must consent in writing (Rule 1.8), 3) the lawyer cannot allow a nonlawyer to engage in UPL (Rule 5.5), 4) no sharing of legal
long-range strategy that should begin today, rather than waiting until the Elder Law attorney or firm experiences declining profits.

We additionally recommend that attorneys who wish to practice Elder Law join NAELA which provides Elder Law attorneys with the opportunity to monitor change in the Elder Law market place on a national rather than on a local or statewide basis. This insight is invaluable. An Elder Law attorney should also seek certification as a Certified Elder Law Attorney (CELA) from the National Elder Law Foundation. The CELA designation has been accredited by the American Bar Association. To become certified as a CELA, an attorney must demonstrate broad experience in Elder Law, obtain continuing legal education in Elder Law and pass a written examination. The CELA designation is an excellent way for an Elder Law attorney to distinguish him or herself from other attorneys and service providers. Many of the services that we have recommended in this article are included in the areas of expertise required of CELAs.

Client’s and their families want comprehensive solutions to a myriad of complex problems. These problems frequently include legal, accounting, insurance and investment issues. In our experience, the client prefers to obtain solutions for these problems from a single professional service provider. The value added, non-traditional services in this article address the client’s needs and desires, while greatly enhancing the value of the attorney’s practice.

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fees with nonlawyers (Rule 5.4), 5) compliance with advertising rules (Rules 7.1-7.5), 6) deliver the ancillary services in a competent manner (Rule 1.1), 7) account for the client’s property (Rule 1.5), 8) avoid representing parties adverse to clients by ancillary business (Rules 1.7 and 1.9), and 9) protect confidentiality of customer information (Rule 1.6). See James M. McCauley, Ethics Counsel, Virginia State Bar, Ethical Issues Arising Out of Elder Lawyers Delivering Law Related Services or Products, 2005 VBA Winter Meeting.

90. Visit the National Elder Law Foundation’s website at www.nelf.org for a description of the requirements to become a CELA and the certification process.
APPENDIX A

ADVANCE MEDICAL DIRECTIVE OF MARY JANE CLIENT

I, MARY JANE CLIENT of Virginia Beach, Virginia, willfully and voluntarily make known my desire and do hereby declare, the following:

I. LIVING WILL

A. Death is as much a reality as birth, growth, maturity, and old age—it is the one certainty in life. If the time comes when I lack decision-making capacity as to decisions for my own future, I wish to make this statement as an expression of my wishes and directions while I am still of sound mind.

B. If at any time my attending physician should determine that (1) I have a terminal condition or (2) I am in a persistent coma from which there is no reasonable possibility of recovery to a cognitive life, where the application of life-prolonging procedures would serve only to artificially prolong the dying process, then I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

C. I understand that “terminal condition” means a condition caused by injury, disease or illness from which, to a reasonable degree of medical probability a patient cannot recover and (1) the patient’s death is imminent or (2) the patient is in a “persistent vegetative state,” which means a condition caused by injury, disease or illness in which a patient has suffered a loss of consciousness, with no behavioral evidence of self-awareness or awareness of surroundings in a learned manner, other than reflex activity of muscles and nerves for low level conditioned response, and from which, to a reasonable degree of medical probability, there can be no recovery.

D. I understand that “life-prolonging procedure” means any medical procedure, treatment or intervention which (1) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function, or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (2) when applied to a patient in a terminal condition, would serve only to prolong the dying process. However, nothing in this declaration shall prohibit the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain, including the administration of excess dosages of pain relieving medications in accordance with Virginia Code § 54.1-3408.1 or any other applicable law.

E. With respect to nutrition and hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make it clear that I intend to include these procedures among the “life-prolonging procedures” that may be withheld or withdrawn under the conditions given above.
Alternate For Paragraph E.

My Agent shall have the authority to decide if nutrition and hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, shall be continued or if nutrition and hydration shall be withheld or withdrawn under the conditions given above.

If Female Client

F. If I have been determined to be pregnant, I direct that all “life-sustaining treatment” be continued during the course of my pregnancy.

Alternate for Paragraphs I B., C., D., E., and F.

I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition. I want my life to be prolonged to the greatest extent possible without regard to my condition, the quality of my life, the chances of my recovery, or the cost of the procedures.

II. MEDICAL POWER OF ATTORNEY

A. I hereby appoint JOHN J. CLIENT as my agent to make health care decisions on my behalf as authorized in this instrument. In addition, in order to provide for succession, in the event that my agent cannot serve or continue to serve or is unavailable to serve, I appoint the following persons to serve as consecutive alternates to my agent named above and who shall serve in the order specified below (in which case all references herein to my “agent” shall refer to my “alternate agent”):

   SALLY M. AGENT, First Alternate
   WILLIAM J. AGENT, Second Alternate

If any alternate agent shall be unable or unwilling or unavailable to serve or to continue to serve as my agent, the next alternate agent named above shall serve as my agent. Any party dealing with any person named as alternate agent hereunder may rely upon as conclusively correct an affidavit or certificate under penalties of perjury of such agent that those persons named as prior agents are unable, unwilling, or unavailable to serve.

Alternate For Paragraph II. A.

I hereby appoint JOHN J. CLIENT and SALLY M. AGENT to serve as my agents to make health care decisions on my behalf as authorized in this instrument.

Second Alternate For Paragraph II. A.

I hereby appoint JOHN J. CLIENT as my agent to make health care decisions on my behalf as authorized in this document. If JOHN J. CLIENT is not reasonably available or is
unable or unwilling to act as my agent hereunder, then I hereby appoint SALLY M. AGENT and WILLIAM J. CLIENT to serve as my successor agents.

B. When it is necessary or appropriate to inquire about my physical or mental health and notwithstanding the condition precedent otherwise contained in this instrument, my agent is authorized to request, receive, and review any information, verbal or written, regarding my physical or mental health, including medical and hospital records. My agent may execute any releases or other documents that may be required to obtain such information and to disclose such information to such persons, organizations, firms or corporations as my agent shall deem appropriate. My agent shall have powers granted by all applicable state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA). For such purposes, I do hereby designate my agent as my “personal representative” with all the authorities granted to such person under HIPAA. The agent may grant releases to hospital staff, physicians, and other health care providers who act in reliance on instructions given by my agent or who render written opinions to the agent from all liability for damages. This authorization is intended to provide my health care providers with the authorization necessary to allow each of them to disclose such general medical information and protected health information disclosed by any such health care provider pursuant to this authorization is subject to further disclosure and use by such designated agents and may thereafter no longer be protected by such privacy rules. This authorization shall remain in effect until the earlier of its revocation by me or my death.

C. I hereby grant to my agent, named above, full power and authority to make health care decisions on my behalf as described below whenever I have been determined to be incapable of making an informed decision about providing, withholding or withdrawing medical treatment. The phrase “incapable of making an informed decision” means unable to understand the nature, extent and probable consequences of a proposed medical decision or unable to make a rational evaluation of the risks and benefits of a proposed medical decision as compared with the risks and benefits of alternatives to that decision, or unable to communicate such understanding in any way. My agent’s authority hereunder is effective as long as I am incapable of making an informed decision.

D. The determination that I am incapable of making an informed decision shall be made by my attending physician and a second physician or licensed clinical psychologist after a personal examination of me and shall be certified in writing. Such certification shall be required before treatment is withheld or withdrawn, and before, or as soon as reasonably practicable after, treatment is provided, and every 180 days thereafter while the treatment continues.

E. In exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this instrument or as otherwise known by my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks, and side effects associated with treatment or nontreatment. My agent shall not authorize a course of treatment which my agent knows, or
upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If my agent cannot determine what treatment choice I would have made on my own behalf, then my agent shall make a choice for me based upon what my agent believes to be in my best interests.

F. The powers of my agent shall include the following:

1. To consent to or refuse or withdraw consent to any type of medical care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation. This authorization specifically includes the power to consent to the administration of dosages of pain relieving medication in excess of standard dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or inadvertently hastens my death. This authorization also specifically includes the power to direct and consent to the writing of a “No Code” or “Do Not Resuscitate” order or an “Emergency Medical Services Do Not Resuscitate Order” by any health care provider;

2. To request, receive and review any information, verbal or written, regarding my physical or mental health, including but not limited to, medical and hospital records, and to consent to the disclosure of this information;

3. To employ and discharge my health care providers;

4. To arrange (upon execution of certificates by two independent psychiatrists who have examined me and who agree that I am in immediate need of hospitalization because of mental disorder, alcoholism, or drug abuse) for my voluntary admission to an appropriate hospital or institution for treatment of the diagnosed problem or disorder; to arrange for private psychiatric and psychological treatment for me; and to revoke, modify, withdraw or change consent to such hospitalization, institutionalization or private treatment which I or my agent may have previously given. The consent of my agent to my hospitalization for psychiatric help, alcoholism, or drug abuse shall have the same legal effect, subject to local law, as a voluntary admission by me;

5. To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, adult home or other medical care facility;

6. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers;

7. To direct my attending physician to enter in my medical records orders preventing resuscitation, intubation, or hospitalization;

8. To make decisions concerning my visitation, subject to physician orders and to the policies of any institution to which I am admitted; and
9. To establish a new residency or domicile for me, from time to time and at any time, within or without the state, and within or without the United States, for such purposes as my agent shall deem appropriate, including, but not limited to any purposes for which this instrument was created.

III. ANATOMICAL GIFTING AND DISPOSITION OF REMAINS

A. Upon my death, I authorize my above-named agent to make an anatomical gift of any part(s) of my body pursuant to Article 2 (§ 32.1-289 et seq.) of Chapter 8 of Title 32.1 of the Virginia Code;

Alternate For Paragraph III. A.

My agent is authorized to oppose and prevent the donation or use of any of my organs, tissues, or body parts for any purpose whatever, and my agent is directed to take such action as may be necessary to prevent such donation or use.

B. To direct the disposition of my remains to the extent authorized by law, including cremation.

IV. AGENTS

A. My agent shall not be liable for the costs of treatment pursuant to its authorization, based solely on that authorization.

B. If any court determines that it is necessary to appoint someone to serve as guardian of my personal affairs, including the responsibility for making decisions regarding my support, care, health, safety, habilitation, education, therapeutic treatment, and residence, then I request the court to give primary consideration to the person serving as my agent hereunder.

C. My agent is authorized to seek on my behalf and at my expense:

1. a declaration judgment from any court of competent jurisdiction interpreting the validity of this instrument and any of the acts authorized by this instrument, but such declaration judgment shall not be necessary for my agent to perform any act authorized by this instrument.

2. a mandatory injunction requiring compliance with my agent’s instructions by any person, organization, corporation or other entity obligated to comply with instructions given to me who negligently or willfully fails or refuses to follow such instructions.

3. actual punitive damages, and the recoverable costs, fees, and expenses of such litigation, against any person, organization, corporation or other entity obligated to comply with instructions given by me who negligently or willfully fails or refuses to follow such instructions.

D. No person who acts in reliance upon any representation my agent may make as to (a) the fact that my agent’s powers are then in effect, (b) the scope for my agent’s authority granted under this instrument, (c) my competency at the time this instrument is executed, (d) the fact that this instrument has not been revoked, or (e) the fact that my agent continues to serve as my agent, shall incur any li-
ability to me, my estate, my heirs, or assigns for permitting my agent to exercise any such authority.

**E.** When I have two or more agents serving at the same time either of my agents may act, (each of whom are individually referred to herein as my “agent”). Either of my agents may exercise the powers and discretions set forth in this instrument either (1) alone and without the approval or consent of any other agent named herein, or (2) jointly with any other agent named herein. Notwithstanding the power granted to any agent named herein to act alone, such agent shall have no power to perform any act to which any other agent objects and no person who prior to acting upon the instructions of any agent shall receive written, signed objection from any other agent, shall be entitled to rely upon such instructions.

**Alternate For Paragraph IV. E.**

When I have two agents serving at the same time, both agents must exercise jointly, by the unanimous consent of both of them at any time so serving, the powers and discretions set forth in this instrument. The affidavit or certificate under penalty of perjury of either of my agents shall be conclusive evidence insofar as third parties are concerned that any act of such agent has been authorized by the unanimous consent of both of my agents. If either of my agents shall die, resign, or be disabled, then I authorize the remaining agent to exercise the powers and discretions set forth below. The affidavit or certificate under penalty of perjury of the remaining agent shall be conclusive evidence insofar as a third person is concerned that the other agent has died, resigned, or is disabled.

**Second Alternate For Paragraph IV. E.**

When I have more than two agents serving at the same time, the agents shall exercise jointly, by the majority vote of all of them at any time so serving, the powers and discretions set forth below. The affidavit or certificate under penalty of perjury of any of my agents shall be conclusive evidence insofar as third parties are concerned that any act of such agent has been authorized by a majority of my agents.

**F.** My agent shall be entitled to compensation for services performed under this advance medical directive and my agent shall also be entitled to reimbursement for all reasonable costs and expenses, including reasonable attorney’s fees, actually incurred and paid by my agent on my behalf at any time under any provision of this instrument.

**Alternate For Paragraph IV. F.**

My agent shall be not be entitled to compensation under this advance medical directive, but shall be entitled to reimbursement for all reasonable costs and expenses, including reasonable attorney’s fees, actually incurred and paid by my agent on my behalf at any time under any provision of this instrument.

**G.** If my spouse has been appointed my agent or an alternate agent and subsequent to the execution of this document, an action is filed to dissolve our marriage,
then the filing of such action shall automatically remove my spouse as agent or alternate agent.

H. The authority of my agent shall cease if my attending physician determines that I have regained capacity. The authority of my agent shall recommence if I subsequently lose capacity and consent for treatment is required.

I. My agent and my agent’s estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, and assigns from all liability and from all claims or demands of all kinds arising out of act or omissions of my agent, except for willful misconduct or gross negligence.

V. ADMINISTRATIVE PROVISIONS

A. This advance directive shall not terminate in the event of my disability or incapacity.

B. If this instrument is revoked or amended for any reason, I, my estate, and my personal representative will hold any person, organization, corporation or entity, hereinafter referred to in the aggregate as “Person,” harmless from any loss suffered, or liability incurred by such Person in acting in accordance with the instructions of my agent acting under this instrument prior to the receipt by such Person or action written notice of any such revocation or amendment.

C. If this instrument has been executed in multiple counterpart originals, each such original shall have equal force and effect.

D. My agent is authorized to make photocopies of this instrument as frequently and in such quantity as my agent shall deem appropriate. Each photocopy shall have the same force and effect as any original.

E. If any part of any provision of this instrument shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity only, without in any way affecting the remaining parts of such provision or the remaining provisions of this instrument.

F. This instrument shall be governed by the laws of the Commonwealth of Virginia in all respects, including its validity, construction, interpretation, and termination. I intend for this instrument to be honored in any jurisdiction where it may be presented and for any such jurisdiction to refer to Virginia law to interpret and determine the validity of this instrument and any of the powers granted under this instrument.

G. By signing below I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this instrument.

Alternate For Paragraph V. G.

By signing below, by my mark, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document.

WITNESS my hand and seal this 18th day of May, 2005.

MARY JANÉ CLIENT
Alternate Signature Line

__________________________________  MARY JANE CLIENT, by her mark

The declarant signed the foregoing advance medical directive in my presence. I am not the spouse or a blood relative of the declarant.

Alternate Witness Declaration

The declarant signed the foregoing advance medical directive, by her mark, in my presence. I am not the spouse or a blood relative of the declarant.

_________________  295 Bendix Road, Suite 170, Virginia Beach, Virginia
Witness   Address

COMMONWEALTH OF VIRGINIA
CITY OF VIRGINIA BEACH, to-wit:

The foregoing instrument was acknowledged before me this 18th day of May, 2005, by MARY JANE CLIENT, and the witnesses, _______________________________ and ___________________________.

My Commission Expires:
Notary Public

Alternate Notary Clause

COMMONWEALTH OF VIRGINIA
CITY OF VIRGINIA BEACH, to-wit:

Before me,___________________, a Notary Public in and for the aforesaid, in the 18th day of May, 2005, personally appeared MARY JANE CLIENT, to me known to be the identical person who executed the within and foregoing instrument by her mark in my presence and the presence of and , as witnesses, and acknowledged before me that she executed the same as her free and voluntary act and deed for the uses and purposes therein set forth.

My Commission Expires:
Notary Public
APPENDIX B

FIDUCIARY INFORMATION
ADVANCE MEDICAL DIRECTIVE OF MARY JANE CLIENT

Agent: John J. Client  
5555 Main Street  
Virginia Beach, Virginia 23462  
Tel: (555) 555-5555

Successor Agent: Sally M. Agent  
1555 South Street  
Virginia Beach, Virginia 23462  
Tel: (555) 555-1111

Successor Agent: William J. Agent  
2323 Lake Street  
Virginia Beach, Virginia 23462  
Tel: (555) 555-2222

APPENDIX C

LETTER TO PHYSICIAN WITH COPY OF ADVANCE MEDICAL DIRECTIVE

David D. Doctor, M.D.  
2747 First Street, Suite 270  
Virginia Beach, Virginia 23462  
Re: Advanced Directives  
Mary Jane Client

March 2, 2005

Dear Dr. Doctor:

Please be advised that this office represents Mary Jane Client. Recently our office prepared an advance medical directive on her behalf. As a courtesy, we are enclosing a photocopy of her advance medical directive for your records.

In the event you have any questions or concerns regarding this correspondence, please feel free to contact my legal assistant, Maryann L. Smith.

Sincerely,

Andrew H. Hook, CELA, AIF  
Attorney at Law  
ah: pkd  
Enclosure  
pc: Mary Jane Client
APPENDIX D

Medication and Medical Form
MARY JANE CLIENT

Allergic To - Do Not Give:

Allergic to:_____________________ Reaction:_____________________________
Allergic to:_____________________ Reaction:_____________________________
Allergic to:_____________________ Reaction:_____________________________
Allergic to:_____________________ Reaction:_____________________________
Allergic to:_____________________ Reaction:_____________________________

Prescribed Medications (RX):

Drug Name:____________________ Generic Name:____________________
Purpose:_______________________ Strength:_______________________
Quantity Taken:_______________ Special Directions:________________
Drug Name:____________________ Generic Name:____________________
Purpose:_______________________ Strength:_______________________
Quantity Taken:_______________ Special Directions:________________
Drug Name:____________________ Generic Name:____________________
Purpose:_______________________ Strength:_______________________
Quantity Taken:_______________ Special Directions:________________
Drug Name:____________________ Generic Name:____________________
Purpose:_______________________ Strength:_______________________
Quantity Taken:_______________ Special Directions:________________

Over-The Counter (OTC) Products (Vitamins, Pain Killers, Muscle Relaxers, Cold, Sinus, etc.):

Name:_______________________ Purpose:_______________________ How Many Are Taken Daily:___________
Name:_______________________ Purpose:_______________________ How Many Are Taken Daily:___________
Name:_______________________ Purpose:_______________________ How Many Are Taken Daily:___________

Chronic Medical Conditions:

Condition:______________________ Specialist:______________________ Diagnosed:______________________
Condition:______________________ Specialist:______________________ Diagnosed:______________________
Specialist: __________________________

Other Medical Conditions:

Condition: __________________________
Specialist: __________________________ Diagnosed: __________________________
Condition: __________________________
Specialist: __________________________ Diagnosed: __________________________

Physician(s):

Primary Care Doctor __________________ Telephone Number: __________________
Emergency Number: __________________
Specialist: __________________________ Telephone Number: __________________
Emergency Number: __________________

Insurance: Primary: Carrier (i.e. Prudential etc.): __________________
Policy #: __________________
Phone #: __________________
Policy Holders Name: __________________

Insurance: Secondary: Carrier (i.e. Prudential etc.): __________________
Policy #: __________________
Phone #: __________________
Policy Holders Name: __________________

APPENDIX E

WALLET CARE TO BE LAMINATED

NOTICE TO MEDICAL PERSONNEL

I, MARY JANE CLIENT, have executed an ADVANCE MEDICAL DIRECTIVE. If I am ever found in a condition in which I am unable to make my own health care decisions, my designated agent has the legal authority to make those decisions on my behalf. In such an event, one of the persons listed on the reverse of this card should be contacted immediately, in the order listed.

(See Reverse Side)

My Agent’s Names:

JOHN J. CLIENT
(555) 555-5555
SALLY M. AGENT
(555) 555-1111
WILLIAM J. AGENT
(555) 555-2222
BASIC STRATEGIES FOR SSI PLANNING

John J. Campbell, CELA*

I. INTRODUCTION

The primary goal of disability planning is to preserve eligibility for all available and appropriate governmental benefit programs, including Supplemental Security Income (SSI) and Medicaid. Typically, Medicaid eligibility is the first consideration because the need to ensure adequate medical care is paramount. However, SSI is also

* John J. Campbell, CELA, the founder and principal attorney of the Law Offices of John J. Campbell, P.C., has practiced law for nineteen years and has concentrated in the practice of Elder Law for nine years; and is certified as an Elder Law Attorney by the National Elder Law Foundation. Mr. Campbell is licensed to practice law in Colorado and is also licensed and on inactive status in Missouri. He is a member of the Colorado Bar Association, the Arapahoe County Bar Association, the Missouri Bar Association, the National Structured Settlements Trade Association, the National Alliance of Medicare Set-Aside Professionals and the National Academy of Elder Law Attorneys. Mr. Campbell has published numerous articles and has presented numerous seminars on issues relating to Elder Law across the country.
an important benefit program that can provide much needed additional income, and sometimes more, to those who qualify.

This article focuses on some basic planning strategies to maintain or obtain SSI eligibility; and will discuss differences between the strategies and techniques of SSI eligibility planning and those used in traditional single focus Medicaid eligibility planning. Before moving on to a discussion of SSI eligibility planning, it is important to understand some basics about SSI coverage and the federal regulations governing SSI eligibility.

II. SSI-101: THE BASICS

Supplemental Security Income (SSI) is a financial needs-based public benefit program, which provides income to the elderly, blind or disabled. SSI is federally funded and governed solely by federal law. SSI does not pay for medical care. However, in certain states, individuals who are eligible for SSI will be eligible to have medical benefits through the Medicaid program. An individual applying for SSI must meet strict income and resource tests to qualify.

The monthly income limits for SSI are identical to the maximum federal SSI benefit: $579 for an individual and $869 for a married couple. Generally, any asset that is spent or disposed of by the individual in the same month as it is received is considered “income.” Income under SSI regulations consists of both earned and unearned income.

Earned income consists of wages; and net earnings from self-employment, such as a sheltered workshop. Unearned income consists of income from other sources, including support and maintenance furnished in cash or in kind; payments from an annuity, worker’s compensation payments, old-age, survivors and disability insurance payments, unemployment benefits; payments occasioned by the death of another (which would include payments from an inheritance, payments from a life insurance policy, or payments from a wrongful death action); support and alimony payments; and earnings of

1. The type of Medicaid planning referred to here is strictly planning for Medicaid eligibility in the community. Planning for Medicaid long term care or Home and Community Based Services (HCBS) benefits is governed by different eligibility criteria. Eligibility for these latter benefits is not dependent upon eligibility for SSI, even in SSI states.
3. These are the maximum SSI benefits applicable in 2005. SSI benefit amounts typically increase each year due to cost of living adjustments. Most, but not all states, also allow for a state contribution, which will increase the individual benefit. In these states, the income limit for SSI eligibility is equal to the maximum federal SSI benefit plus the state contribution amount. State contributions to a beneficiary’s SSI benefit are not counted as income in determining the beneficiary’s eligibility for SSI. For the purposes of this article, it will be assumed that no state contribution amount applies.
4. 42 U.S.C. § 1382a(a)(1) (2004). Sheltered workshop programs are available in many communities to assist students completing a special education program to make the transition into the work force. Such programs typically provide vocational training in a working environment and eventual transition to employment.
and additions to the corpus of a non-exempt trust of which the individual is a beneficiary.\textsuperscript{5}

SSI exempts the first $20 per month of unearned income; and the first $65 of earned income and one-half of monthly-earned income over $65.\textsuperscript{6} In some states, SSI beneficiaries will also receive a state benefit in addition to their federal SSI benefit. These state payments are also exempt, as are certain other types of income enumerated in the regulations.\textsuperscript{7} These income exemptions are often referred to as the “income disregards.”

With some exceptions, individuals qualifying for SSI must have nonexempt income below $579. Earned and unearned income from sources other than SSI, after deducting the income disregards, will offset an individual’s SSI benefit on a dollar-for-dollar basis.\textsuperscript{8} An offset for other income that reduces an individual’s SSI benefit to $0 will render the individual ineligible.

The regulations also place restrictions on resources. Resources are assets consisting of cash or other liquid assets that (i) could be converted to cash and (ii) are not spent or disposed of in the month received.\textsuperscript{9} Certain exempt resources, including but not limited to a house, a car, personal property, household goods, a burial space, or pre-need agreement\textsuperscript{10} are not counted. Non-exempt resources are restricted to a total of no more than $2,000 for individuals and $3,000 for married couples.\textsuperscript{11}

In thirty-two states and the District of Columbia\textsuperscript{12}, individuals who qualify for SSI automatically qualify for Medicaid. These states are also called “§1634 states.” In seven other states\textsuperscript{13}, the “SSI criteria states,” individuals who qualify for SSI will also qualify for Medicaid, but must file a separate application. Thus, for individuals living in one of these §1634 or SSI criteria states,\textsuperscript{14} SSI provides not only income to help pay for basic living needs, but also provides the “gateway” to Medicaid benefits to cover the costs of medical care.

SSI planning involves issues and strategies similar to those used in traditional Medicaid planning. For instance, both SSI laws and Medicaid laws contain provisions

\ \textsuperscript{5} 42 U.S.C. § 1382a(a)(2) (2004).
\textsuperscript{7} Id.
\textsuperscript{8} 42 U.S.C. §§ 1381a, 1382a(a) (2004).
\textsuperscript{9} 20 C.F.R. § 1201(a) (2004).
\textsuperscript{10} 42 U.S.C. §§ 1382b(a), (d) (2004).
\textsuperscript{12} These are often referred to as “§ 1634 states”: Alabama, Arizona, Arkansas, California, Colorado, Delaware, Georgia, Florida, Kentucky, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Jersey, New Mexico, New York, North Carolina, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin, Wyoming and Washington D.C.
\textsuperscript{13} These are often referred to as “SSI criteria states”: Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon and Utah.
\textsuperscript{14} The § 1634 states and SSI criteria states are collectively referred to in this article as “SSI states.”
III. TRANSFERS WITHOUT FAIR CONSIDERATION

Individuals often consider making gifts of their excess resources to reduce those resources to eligibility levels. To prevent the abuse of this strategy, federal laws impose penalty periods for certain transfers without fair consideration during the “look back period” of thirty-six months preceding the filing of the SSI application. During a resulting penalty period, the individual may not qualify for SSI.

To calculate the penalty period for any transfers of resources, the total uncompensated value of all transfers made during the look back period is divided by the maximum SSI benefit plus any corresponding state payment. Under Medicaid law, the penalty period is calculated by dividing the uncompensated value of the transfer by the average monthly cost of nursing home care for an individual in the state in which the individual lives. The average monthly costs of nursing home care in every state will substantially exceed the maximum SSI benefit. Thus, any transfer without fair consideration will usually result in a longer penalty period under SSI law than that which would be calculated under state Medicaid regulations. However, the SSI transfer provisions, unlike the Medicaid transfer provisions, limit the maximum penalty period to thirty-six months.

While transfers of resources are generally penalized under SSI law, the following transfers of resources are exempt and will not incur a penalty period:

1. Transfer of the home to a) the transferor’s spouse; b) the transferor’s child who is blind, disabled or under 21 years old; c) the transferor’s sibling who has an equity interest in the home and has resided in the home for 1 year immediately before the transferor becomes institutionalized; or d) a child of the transferor who resided in the transferor’s home for 2 years immediately before the transferor becomes institutionalized and who provide care to the transferor which permitted him to reside at home rather than in an institution or facility;

18. Alternatively, states are permitted to use the average monthly cost of nursing home care for the region of the state in which the individual lives.
2. Resources transferred to a) the transferor’s spouse or to another for the sole benefit of the transferor’s spouse; and b) from the transferor’s spouse to another for the sole benefit of the transferor’s spouse;
3. Resources transferred to the transferor’s child who is blind or disabled, or to a trust established solely for the benefit of the transferor’s child who is blind or disabled;
4. Resources transferred to a trust established solely for the benefit of an individual who has not attained 65 years of age and who is disabled;
5. Transfers which were a) intended to be made at fair market value or for other valuable consideration; or b) exclusively for a purpose other than to qualify for SSI benefits; or c) where all resources transferred have been returned to the transferor; and
6. Transfers in cases where the Commissioner determines that denial of benefits would work an undue hardship.

These transfer exclusions are essentially the same as those for Medicaid long-term care and Home and Community Based Services (“HCBS”) benefits. The considerable difference is that Medicaid has a thirty-six month look back period in most states, but can have an indefinite penalty period; while the resulting penalty period under SSI will be longer than the Medicaid transfer penalty but it can never be longer than thirty-six months.

IV. DIFFERENCES IN THE TREATMENT OF TRUSTS

A. Medicaid Special Needs Trusts and Pooled Trusts under OBRA ’93

The Omnibus Budget Reconciliation Act of 1993 (OBRA ’93) established new Medicaid rules for treatment of both revocable and irrevocable trusts created after August 10, 1993. The general rule is that, in determining an individual’s eligibility for Medicaid benefits, trusts “established by such individual” will be included in income or available resources to the extent of any discretion exercisable in favor of the individual or the individual’s spouse. A trust is “established by such individual” when the individual’s assets form all or part of the corpus of a non-testamentary trust settled by the individual, his or her spouse, or a third person with legal authority to act for the individual or the spouse.21 In short, a trust created with the Medicaid applicant’s funds generally cannot be used to keep the applicant under the income or available resource ceilings for Medicaid eligibility.

Two exceptions to this general rule are contained in 42 U.S.C. § 1396p(d)(4)(A) and (C), which, respectively, provide for a special needs trust for a disabled individual under age 65, or pooled trust account for a disabled individual regardless of age.22 Special needs trusts, established by the individual’s parent, grandparent, legal guard-

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22. While a pooled trust can be created for a disabled individual of any age, many states impose a transfer penalty for the funding of such an account by a person over age 65.
ian, or by a court, (often called “(d)(4)(A)” or “payback” trusts), and pooled trust accounts established by the individual, the individual’s parent, grandparent, legal guardian, or by a court, (often called “(d)(4)(C)” trusts), will be excluded as a resource for purposes of determining Medicaid eligibility. It is important to note that despite the provisions of §1396p(d)(4)(C), many states impose transfer penalties on transfers to pooled trusts for individuals over age sixty-five.

Within the parameters of the statute, OBRA '93 has liberalized the use of trusts for individuals with disabilities. However, OBRA '93 does not clarify the standard of distribution for these trusts. Nevertheless, there is an implied Congressional intent that the trusts remain “supplemental” and discretionary. The Centers for Medicare and Medicaid Services (formerly the Department of Health Care Financing Administration) issued an advisory opinion, defining the standard for distribution to be for discretionary special needs.  

Finally, the federal statute requires that after the death of the trust beneficiary or after the trust is terminated during the beneficiary’s lifetime, (whichever occurs sooner) the state must be reimbursed from the assets remaining in the trust to the extent of the total medical assistance dollars paid.

B. FCIA Special Needs Trusts and Pooled Trusts: SSI Requirements Under 42 U.S.C. §1382b(e)

In December of 1999, Congress passed the Foster Care Independence Act (FCIA), containing new anti-fraud provisions applicable to the Supplemental Security Income (SSI) program. The FCIA enacted all new provisions regarding treatment of trusts for SSI eligibility purposes. These provisions are contained in 42 U.S.C. §1382b(e).

The FCIA generally disfavors trusts established by individuals with their own funds and treats the corpus of these trusts as “available resources” to the individual. The FCIA provides that an individual is determined to have established a trust if any assets of the individual are transferred to the trust. Trusts created in a will of another, of which the individual is a beneficiary, are not “established by an individual,” and are therefore exempt from the provisions of the FCIA.  

Under the FCIA, the corpus of a revocable trust established by the individual is considered an available resource. In the case of an irrevocable trust established by the individual, that portion of the corpus that could be distributed to or for the benefit of the individual or the individual’s spouse in any circumstance is also considered an available resource. Further, distributions from the corpus of any of these trusts, other

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than to or for the benefit of the individual, will incur a transfer penalty. Actions to foreclose the ability to make distributions from the corpus of these trusts to or for the benefit of the individual will likewise be subject to transfer penalty calculations.

The FCIA specifically exempts OBRA '93 special needs trusts and pooled trusts from being considered an available resource and provides that transfers to fund such trusts by an individual under age 65 will not incur a penalty period. Thus, the FCIA provides that a trust will be exempt from the general rules regarding self-settled trusts if it complies with all of the criteria in 42 U.S.C. §1396p(d)(4)(A) or (C) applicable to OBRA '93 trusts for Medicaid.

However, even a complying (d)(4)(A) or (C) trust might not be recognized as a valid SSI exempt trust if it does not also comply with Social Security Administration (SSA) policies, some of which are not enumerated in the FCIA. These policies are embodied in the Program Operations Manual System (POMS) at POMS SI 01120.203. In particular, the trust must comply with all of the following key requirements, as summarized in POMS SI 01120.203.D.1:

1. The trust will be established with the assets of the beneficiary, who is under age 65;
2. The beneficiary is disabled as that term is defined in the Social Security Act;
3. The beneficiary is the sole beneficiary of the trust. (Further, the trust does not allow any Prohibited Expenses or Payments under POMS SI 01120.203.B.3);
4. The trust was established by the beneficiary’s parent, grandparent, legal guardian or a court, if the beneficiary is a minor. If the beneficiary is not a minor, the trust was established by someone who has legal authority to act with regard to the beneficiary’s assets, as required by POMS SI 01120.203.B.1.e, which would mean that the trust must have been established by the beneficiary’s legal guardian or a Court, or by the individual in the case of a pooled trust account;
5. The Trust provides specific language providing that, upon the death of the beneficiary, the trust must first reimburse the State for medical assistance paid for the beneficiary;
6. The Trust will be fully funded before beneficiary reaches age 65;
7. The Trust is irrevocable. (The Trust must contain a specific provision making the Trust irrevocable; and, in states that still recognize the “doctrine of worthier title,” the Trust must name specific individuals as contingent beneficiaries to receive any remaining trust balance upon the beneficiary’s death and after repayment to the State for medical assistance benefits paid).

Failure of the trust to comply with both OBRA ’93 and with the SSA requirements could result in trust assets being considered an available resource or in transfers to fund the trust being considered a transfer without fair consideration, resulting in a penalty period.

C. Testamentary Special Needs Trusts

Friends, relatives or the spouse of an individual with disabilities often want to provide for that individual in their Wills. However, outright gifts could cause the individual to become ineligible for SSI and Medicaid due to excess resources.

Thus, an important estate-planning tool used in SSI and Medicaid planning for a disabled individual is the Special Needs Trust created in a will. This trust is usually called a “Testamentary Supplemental Needs Trust” or a “Testamentary Special Needs Trust.” Testamentary Special Needs Trusts predate the passage of OBRA ’93; and are specifically exempted from the strict requirements for self-settled living trusts found in both OBRA ’93 and in the FCIA.32

A Testamentary Special Needs Trust, like the living trust under OBRA, can pay for items that improve the quality of a beneficiary’s life and medical care, without jeopardizing his or her eligibility for means-tested benefits programs. This trust can be funded with second-to-die life insurance, in the case of a disabled child; with an annuity, in the case of a disabled spouse; or with any combination of the two, as well as probate assets remaining in the testator’s estate. However if the beneficiary’s own property is added to the existing trust, the transfer of the beneficiary’s property could adversely affect the beneficiary’s eligibility for public benefits.

Like the OBRA ’93 trust, the Testamentary Special Needs Trust must be irrevocable. The trust must not permit the beneficiary to compel the trustee to make any distributions from the trust. In addition, trust property used for the beneficiary’s support, rather than to supplement public benefits, will be considered “income” to the beneficiary.

The Testamentary Special Needs Trust is created under the terms of a will. The trustee appointed may be the same person appointed as the testator’s personal representative or executor. The testator also may change any terms of the trust or eliminate the trust provisions altogether simply by later executing a new will.

The trust does not come into being and is not funded until after the testator’s death. The testator may direct that property remaining in the trust upon the beneficiary’s death be paid to anyone the testator desires.

Some state Medicaid regulations effectively limit the funding of Testamentary Special Needs Trusts for the benefit of a surviving spouse. In Colorado, for example, if all of a testamentary devise to a surviving spouse is placed into a Testamentary Special Needs Trust, the surviving spouse will be required to petition the Probate Court for his or her spousal elective share, exempt property and family allowance as provided in the Probate Code. Failure to do so will be considered a transfer without fair consideration and will trigger a penalty for long-term care and HCBS benefits.33

However, any property remaining after distribution of the elective share, exempt property, or family allowance to the surviving spouse may be placed safely into a Testamentary Special Needs Trust for the surviving spouse.

The restrictions applicable to Testamentary Special Needs Trusts for the benefit of a surviving spouse do not apply to Testamentary Special Needs Trusts for the benefit of a disabled child, friend, grandchild, etc.

D. Third-Party Special Needs Trusts

The common law still recognizes that when a person is disabled, his or her loved ones may wish to provide for the person by creating a living Special Needs Trust.\(^{34}\) This Third-Party Special Needs Trust is intended to supplement the person’s public benefits, yet not jeopardize any other sources of payment, such as SSI or Medicaid, that might already exist.

The criteria for Third-Party Special Needs Trusts are that:

a) The grantor must owe no duty of support to the beneficiary;

b) The trust must be irrevocable;

c) The trust may not provide for the daily support of the beneficiary (such as food and shelter) without such distributions being considered “income” to the beneficiary;

d) The beneficiary cannot compel distributions and has no power to amend the trust; and

e) Money or property of the disabled beneficiary may never be added to or used to fund the trust.\(^{35}\)

A Third-Party Special Needs Trust is distinguishable from an OBRA ’93 Special Needs Trust and is not required to comply with the same OBRA ’93 and FCIA restrictions applicable to self-settled trusts. Thus, Third-Party Special Needs Trusts remain a valuable planning technique and, in many cases, are preferable to OBRA ’93 Special Needs Trusts.

E. Differing Treatments of Income under SSI and Medicaid

It is important to understand and adhere to the strictly construed guidelines on distributions from Special Needs Trusts under both the SSI and Medicaid regulations. Distributions from a Special Needs Trust that provide support to the disabled individual, whether in cash or in kind, will be treated as income to the individual and could disqualify the individual from eligibility.

Distributions of cash to the individual will be counted as income on a dollar-for-dollar basis under both SSI and Medicaid regulations and can easily disqualify the individual from both SSI and Medicaid. Distributions from the trust for the beneficiary’s support, other than direct cash distributions to the beneficiary, (i.e., distributions to third parties to purchase the beneficiary’s food or shelter, including essential utilities, such as gas, electric, water and sewer services) will be treated as in-kind income

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\(^{35}\) *Id.*
under both SSI and Medicaid regulations. However, the value of in-kind income is calculated differently under SSI regulations than under Medicaid regulations.

Under Medicaid regulations, in-kind income is usually treated the same as cash income and is valued on a dollar-for-dollar basis. Thus, the trustee must be careful not to make distributions that would count as in-kind income to a Medicaid beneficiary whose eligibility is not due to SSI, as it can cause loss or reduction of benefits just as quickly as will distributions of cash.

In contrast, SSI regulations provide that the value of in-kind income for support will be determined under either the “one-third reduction rule” or the “presumed value rule.” Whether the trust pays out $5000 or $500 for in-kind income each month, the reduction in the beneficiary’s SSI benefits will be the same because the reduction is based on a set formula that is not necessarily related to the actual value of the in-kind income provided. However, if the value of in-kind income received by a beneficiary each month is less than the reduction calculated under the one-third reduction rule or the presumed value rule, whichever is applicable, the beneficiary’s benefit will only be reduced by the actual value of the in-kind income received.

If an individual on SSI is living in another person’s household and receives both food and shelter from that person, the value of in-kind income for support provided to the individual will be computed according to the “one-third reduction rule.” However, if the individual lives in his or her own household, or in the household of another person, but does not receive both food and shelter from that other person, the “presumed value rule” applies. The presumed value rule could result in a slightly larger amount being treated as income to the individual. However, so long as the beneficiary will still be entitled to a monthly SSI benefit of $1 or more after reduction for in-kind income, the beneficiary will still be considered eligible for SSI.

Income (and resources) can also be “deemed” under SSI regulations. That is, an individual living at home with his or her ineligible spouse or child will be deemed to have access to a portion of the spouse’s or child’s income. Generally, an individual under age 18 living with his or her family will also be deemed to have access to a portion of his or her ineligible parents’ incomes. However, for individuals who do not live in the same home as their families, the income of a spouse, child, or parent is not deemed available. For individuals who have resident alien status and are eligible for SSI, the income and resources of a sponsor are deemed to the individual, regardless of whether they live in the same household.

36. The “one-third reduction rule” states that the beneficiary’s benefit will simply be reduced by one-third of the maximum SSI benefit. 20 C.F.R. § 416.1131 (2004).
37. The “presumed value rule” states that the presumed value of support and maintenance in kind equals one-third of the maximum SSI benefit plus the unearned income exclusion (currently $20). 20 C.F.R. § 416.1140 (2004).
38. 20 C.F.R. § 1131(a) (2004).
F. 209(b) States

In the 39 SSI states (and the District of Columbia), an individual who qualifies for SSI will also be able to qualify for Medicaid. However, there are eleven states that are permitted to use criteria for Medicaid eligibility that are more restrictive than SSI criteria. These states are commonly referred to as “209(b) states” because the statutory exception which allows these states to employ stricter Medicaid eligibility criteria is contained in §209(b) of the Social Security Act.

In 209(b) states, for instance, income limits are usually stricter than in SSI states. However, an individual can spend down his or her excess income on medical care and be able to qualify for Medicaid. Rules regarding deemed income can also be stricter in 209(b) states, where a spouse’s or parent’s income may be deemed available to a Medicaid applicant, even if the applicant is not living in the same home as the spouse or parent.

The ability of 209(b) states to impose stricter eligibility criteria than SSI is not limited to financial criteria. Criteria for determining disability may be stricter in 209(b) states; or Medicaid eligibility for disabled persons may be limited to persons age 18 years or older. However, if a state limits eligibility to persons 18 years of age or older, the state must grant Medicaid eligibility to persons age 18 who are eligible for SSI and who would be eligible under the state’s AFDC program, but for those persons’ SSI benefits.

Finally, 209(b) states must apply the same Medicaid eligibility criteria to SSI recipients as are applied to individuals who do not qualify for SSI.

V. DO SSI OR MEDICAID CRITERIA APPLY?

The Ramey decision, issued on October 1, 1999, considered, among other things, (i) whether, in an SSI state, a trust approved under the federal SSI eligibility criteria could nonetheless be considered invalid under state Medicaid law; and (ii) whether a Medicaid beneficiary in an SSI state can be denied Medicaid benefits under state Medicaid regulations if the individual continues to qualify for SSI.

The case involved three plaintiffs, all severely disabled with multiple sclerosis. All three had self-settled trusts. The main issue before the Court was whether the individual trusts were available resources in excess of $2,000 to the respective plaintiffs. In analyzing the trusts, the State of Colorado attempted to apply the federal and state
laws relative to Medicaid Qualifying Trusts, and the Colorado Medicaid laws requiring that all trusts for Medicaid beneficiaries be approved by the state Medicaid agency.

The Court correctly determined that Colorado is a state in which an individual who is eligible for SSI benefits is categorically eligible for Medicaid. The Court held that, since the plaintiffs’ trusts were approved by the Social Security Administration and, given that the plaintiffs were qualified for SSI, the state was required to grant them Medicaid benefits, regardless of whether their trusts complied with the state’s Medicaid law.50 The District Court, following another prominent holding,51 found that the Medicaid agencies in SSI states cannot employ methodology or criteria more restrictive than that of SSI when evaluating trusts.

Since the Social Security Administration had already approved two of the trusts, the Court held that the State of Colorado could not now fail to approve the trusts. Further, the Court held that the state Medicaid agency had no independent right to review the trusts once the trusts had been approved by Social Security.

The District Court’s opinion was affirmed in 2001 by the United States Court of Appeals for the 10th Circuit in *Ramey v. Reinertson*, 268 F.3d 955 (10th Cir. 2001). The Court’s holding in *Ramey* reaches beyond the treatment of SSI-approved trusts. It governs any situation in which an SSI state’s Medicaid regulations impose more restrictive criteria for eligibility than the federal regulations governing SSI.

The result is that, in an SSI state, an individual who is eligible for SSI under the federal Social Security regulations cannot be denied Medicaid benefits due to the application of a more restrictive state law or regulation. However, 209(b) states are still permitted to use Medicaid eligibility criteria that are more restrictive than SSI criteria.

VI. SPECIAL PLANNING CONSIDERATIONS FOR SSI

A. Planning for Individuals in SSI States

To SSI beneficiaries living in SSI states, the *Ramey* case is extremely important. In these states, a trust which is approved by the Social Security Administration for an SSI beneficiary is not required to comply with any additional state requirements. Additionally, an individual who qualifies for SSI cannot be denied Medicaid under state Medicaid laws imposing more restrictive eligibility requirements than those imposed by SSI.

Thus, for the Medicaid recipient who is eligible for SSI, that person’s Special Needs Trust must comply with SSI criteria, regardless of state Medicaid criteria. Further, if such an individual qualifies for SSI, even after consideration of all cash and in-kind income, that individual cannot be denied Medicaid benefits, even if a calculation of the individual’s in-kind income under state Medicaid regulations might otherwise result in ineligibility.

50. Id.
If the Special Needs Trust beneficiary’s Medicaid eligibility is due to SSI eligibility, a Special Needs Trust must be drafted and created in accordance with both OBRA ’93 criteria and the SSI criteria found in the POMS. This will require that certain trust provisions be more restrictive than required under Medicaid regulations alone.

When a Special Needs Trust is created for an adult beneficiary, SSI will not recognize the trust as valid if it is created by the beneficiary’s parent or grandparent. This is because SSI does not consider a parent or grandparent to have complete legal authority over the assets of an adult child or grandchild, even when the parent or grandparent is acting under a power of attorney. Thus, a Special Needs Trust for an adult beneficiary must be created by a court or by the beneficiary’s legal guardian, or the beneficiary in the case of a pooled trust account, to satisfy SSI requirements in the POMS.

The POMS also require in “doctrine of worthier title” states that the trust must name at least one specific individual as the ultimate contingent beneficiary, after repayment to the State for medical assistance benefits provided. In “worthier title” states, it is not sufficient merely to name the beneficiary’s estate as contingent beneficiary or name the beneficiary’s heirs at law under the state’s laws of intestacy. Without a specifically named individual beneficiary, the Trust is not irrevocable for SSI purposes; further, the assets in the trust will be treated as available to the beneficiary.

The Special Needs Trust should also be drafted carefully to take advantage of the more liberal treatment of in-kind income under the SSI regulations. Recall that the monthly reduction in SSI benefits resulting from the receipt of in-kind income is not necessarily related to the actual value of in-kind income received. For example, if an individual receives $500 in groceries each month, the reduction in that individual’s SSI benefit will be the same as if the individual receives free rent, groceries and utilities each month valued at $5,000. The ability to receive in-kind income from the Special Needs Trust can be of great value to an SSI beneficiary living in an SSI state.

Therefore, the trust should provide that distributions from the trust be limited to non-cash distributions to the beneficiary or cash distributions paid to third parties on behalf of the beneficiary. Cash distributions to third parties may be for the purchase of support items or for the purchase of non-support items or supplemental needs not covered by public benefits. Examples of these non-support or supplemental needs items could include: a specially equipped van or other vehicle for transportation; color televisions, other entertainment appliances or computers; periodical subscriptions; personal care goods; electric wheelchairs; other supportive devices; or professional health-care services not otherwise covered by Medicaid. Distributions for non-support or supplemental needs will not be counted as either cash income or in-kind income to the beneficiary.

However, the distribution of in-kind income to an individual who may not be receiving the full SSI benefit of $579 per month can cause problems. Under the presumed value rule, if the individual’s monthly SSI benefit is equal to an amount less than $20 plus one-third of the maximum benefit, the offset from in-kind income will reduce the individual’s SSI benefit to $0 and will result in ineligibility. Under the one-third reduction rule, the same result will occur if the individual’s monthly SSI benefit is less than one-third of the maximum SSI benefit before the offset.
Thus, cash distributions from the trust to third parties to purchase support items constituting in-kind income should be limited to situations where the SSI reduction for in-kind income will not result in a complete offset of the beneficiary’s monthly SSI benefit. This will require that the trustee knows which rule will apply to the calculation of the individual’s benefit reduction for in-kind income; and will also require that the trustee have current and accurate information on the exact amount of the individual’s monthly SSI benefit.

If an individual planning for SSI chooses to make gift transfers to reduce his or her resources to SSI eligibility levels, the applicable SSI regulations will result in large penalty periods for small gifts, but will limit the maximum period of ineligibility to thirty-six months. In contrast, gift transfers to become eligible for Medicaid long-term care or HCBS benefits will result in shorter penalty periods for small transfers, but there is no limit on the length of the penalty period if the transfer was made within thirty-six months before applying for Medicaid.

For example, if an individual lives in a state that provides no state SSI contribution payment and where the average monthly cost of Medicaid nursing home care is $5000, a gift transfer of $20,000 will result in a 4-month penalty period under Medicaid regulations. ($20,000 ÷ $5,000 = 4 months.) On the other hand, the same gift transfer under SSI regulations would result in a penalty period exceeding 34-months! ($20,000 ÷ $579 = 34.54 months.) Any gift planning will have to be based on the more restrictive SSI regulations. Otherwise, a gift transfer could result in a significant and unexpected additional delay in the individual’s ability to qualify for either SSI or Medicaid.

If the SSI applicant chooses to make gift transfers to qualify for SSI, it is preferable to make gifts to persons who may not need or want to spend their gifts on themselves. If these individuals voluntarily use their gifts to provide in-kind support to the applicant, the resulting in-kind income will be treated in the same manner under SSI regulations as in-kind income from a trust.

The danger here is that those individuals receiving gifts can be under no legal obligation to provide any support to the applicant from gift proceeds. Otherwise, the arrangement may be treated as an implied trust and result in the entire amount of the gift being counted among the individual’s non-exempt resources. This would completely defeat the purpose for making the gifts: to reduce the individual’s resources below eligibility levels.

B. Planning for Individuals in 209(b) States

For individuals who live in 209(b) states, both SSI and Medicaid regulations will have to be considered in any plan to achieve eligibility. If the individual wishes to become eligible for both SSI and Medicaid, each option under the plan will need to be based on the most restrictive regulation applicable in that individual’s particular state.

Thus, these individuals will need to follow the more restrictive SSI regulations regarding creation of trusts and transfers without fair consideration. At the same time, they may not be able to take advantage of the liberal SSI treatment of in-kind income or deemed income. Non-cash distributions from a Special Needs Trust or from other
third parties will need to be limited to non-support items not provided by available public benefits.

For these individuals, combined SSI and Medicaid planning may be less attractive than traditional Medicaid planning alone. For all of the additional sacrifice over and above the Medicaid eligibility requirements, the additional benefit for SSI eligibility will be limited to the maximum SSI benefit of $579 per month, plus the state contribution amount, if any. The decision to pursue a combined SSI and Medicaid eligibility plan or a plan solely to achieve Medicaid eligibility will depend largely on the Medicaid regulations applicable in the individual’s state of residence.

VII. CONCLUSION

Many of the basic tools used in planning for means tested public assistance, such as gifting or the use of various types of trusts, are applicable to both SSI and Medicaid planning. However, planning for SSI eligibility involves strategies and options that differ from those used when planning for Medicaid alone. This is due largely to differences between SSI and Medicaid regulations governing the treatment of trusts, transfers without fair consideration and in-kind income.

For individuals who live in SSI states, these differences can provide greater flexibility in the administration of Special Needs Trusts and the receipt of in-kind income, since Medicaid eligibility is automatic for applicants who qualify for as little as $1 per month in SSI benefits. However, these differences can also result in having to meet more restrictive criteria regarding the creation of trusts and the penalty periods imposed for making gift transfers.

For individuals living in 209(b) states, it will be necessary to plan for both SSI and Medicaid eligibility by complying with the most restrictive SSI or Medicaid regulations applicable. Thus, the Medicaid regulations applicable in the individual’s particular state will be extremely important in choosing these strategies and options.

Eligibility planning for SSI is extremely complex, especially where the goal is to preserve or achieve eligibility for both SSI and Medicaid. Such planning requires experience and an in-depth knowledge of both SSI and Medicaid regulations. As a result, individuals planning for SSI and/or Medicaid eligibility should always seek the advice and guidance of an Elder Law attorney experienced in this area.
NOTE

MORENZ v. WILSON-COKER

415 F.3d 230 (2d Cir. 2005)

This case holds that federal law requires state Medicaid programs to honor “spousal refusal.” Specifically, the Morenz decision handed down by the Second Circuit Court of Appeals affirmed a district court’s grant of Summary Judgment. This judgment ordered the Commissioner of the Connecticut Department of Social Services (DSS) to rule as Medicaid eligible a man who, instead of utilizing his wife’s assets, assigned to the DSS his rights to claim spousal support from the wife along with his application. 321 F.Supp.2d 398 (D. Conn. 2004).

René H. Reixach, a NAELA Fellow, a partner in Woods Oviatt Gilman LLP, Rochester, New York, and Jane L. Tyree, an attorney with Hersh & Fowler-Cruz, LLP in Westport, Connecticut, successfully argued the case for Mr. Morenz.

Mr. and Mrs. Morenz had paid privately for Mr. Morenz’s nursing home care for several years. The couple’s only income, other than from savings, consisted of Social Security benefits. Mr. Morenz’ Medicaid application presented Mrs. Morenz’ “spousal refusal” statement (that she would not apply any of her excess resources toward the cost of her husband’s care) and Mr. Morenz’ assignment to the State of his support rights. Mrs. Morenz, as her husband’s attorney-in-fact, actually signed the assignment, raising arguments about its validity which were thoroughly discussed by the district court but abandoned by the DSS Commissioner on her appeal. The DSS denied the application because Mrs. Morenz had resources in excess of the Community Spouse Resource Allowance. The trial court ordered that Mr. Morenz was, in fact, eligible for Medicaid. The Commissioner appealed.

The court of appeals decision holds that federal law, 42 U.S.C. § 1396r-5(c)(3)(A), is clear and is buttressed by the interpretation of the Centers for Medicare and Medicaid Services (the “CMS”): an institutionalized spouse may not be denied Medicaid because of excess resources held by the community spouse if the application includes a “spousal refusal” statement and the applicant’s assignment of support rights to the state. Following Supreme Court precedent, the court did not address the State Commissioner’s policy arguments about why spousal refusal is a bad idea since the statute is clear.

The decision also implicitly recognizes CMS’ position, described in section 3260.1 of its State Medicaid Manual, that a support right is whatever state law says it is. The Health Care Financing Administration (“HCFA”), CMS’ predecessor,
circulated a letter to the North Carolina Medicaid agency in 1994 stating that spousal refusal did not apply in that state because it had no enforceable support rights applicable to community spouses. (At the time, North Carolina’s traditional “marital fault” statute did not impose a spousal duty of support. An updated version adopts the more usual rule that spouses are liable to support each other to the reasonable extent of their means.)

The decision in *Morenz* can be expected to reshape spouses’ eligibility for Medicaid within the Second Circuit. Its immediate impact in Connecticut is likely to be great because it provides a mechanism for obtaining Medicaid without forcing the community spouse to deplete savings she needs to live on in her own retirement. In Connecticut the community spouse resource allowance can be as low as $19,100. Many women find themselves in Mrs. Morenz’s situation; considerably younger than their husbands, their only income after their husbands die would be the husband’s Social Security. Mr. Morenz’ attorneys demonstrated, in this case, that property taxes and homeowner’s insurance alone would consume half of that income. By directing states to accept assignment of support claims, the appeals court implicitly recognized that state claims would be adjudicated on a case by case evaluation, allowing the community spouse to argue for essential fairness and against impoverishment.

New York has traditionally recognized “spousal refusal,” but now Connecticut and Vermont are sure to follow. But the significance goes beyond borders of the Second Circuit. As the only reported decision on this issue and, moreover, originating from a well respected circuit court of appeals, other circuits are going to be hard pressed not to follow the court’s “plain meaning” interpretation of Medicaid law. The decision turns, at least partly, on whether there was a support obligation under state law. Such obligations are set forth in statute in most states, but others may also embrace spousal support via the common law doctrine of necessaries or under community property rules.

The court’s procedural holding that a federal court may order retroactive relief, i.e. relief covering a period up to three months prior to the date of its order, is particularly significant. Medicaid officials had, usually with success, argued that for a federal court to grant retroactive benefits violated the Eleventh Amendment. The possibility of being granted retroactive benefits, alone, may induce more claimants to seek justice in the federal courts. This three month “bubble” will allow the parties and the court time to get the case and a motion for preliminary or permanent relief filed, briefed, and hopefully decided without benefits being lost in the interim.

This case establishes what may be a more straightforward way to obtain Medicaid eligibility in spousal cases than other approaches such as using annuities. It will be important to evaluate the facts of the community spouse’s situation to see if there will be equitable defenses to the state’s claim for full reimbursement. It also will be important to determine what support rights one spouse has against the other spouse under state law, and whether there is any automatic assignment of those rights to the state Medicaid agency by operation of law or on the Medicaid application form. If there are support rights, but they are not automatically assigned, as was the case in Connecticut, then a written assignment form should be used if the patient or attorney-
in-fact is able to sign it. Explicit authority for this could be included routinely in the powers in a durable general power of attorney where the client is married.

Future litigation on this issue is likely. On August 17, 2005, a Superior Court justice in Massachusetts reversed a denial of benefits by the state’s Medicaid authority which had been based on the refusal of a community spouse to provide information about her assets. The application, as in Morenz, included an assignment of rights to support as well as the community spouse’s “spousal refusal.” Arlene Rossetti v. Beth Waldman, former Commissioner, Essex Sup. Ct. Civil Action No. 04-1418. Given the clarity of the statute and the longstanding CMS interpretation that it means what it says, any change would have to come from Congress. While spousal refusal has been mentioned as a possible issue for statutory change along with the transfer of assets rules, it should not be singled out for change since it is just one of many provisions enacted in the 1988 spousal impoverishment legislation that provide safety valves to protect spouses from otherwise rigid eligibility formulas.