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Elder Law Attorney

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

Chair to Chair

Howard S. Krooks
Outgoing Chair

When I first stepped into the role as Chair in June 2004, I outlined the following objectives on behalf of the Section:

1. **Establish Ongoing Lobbying Efforts**—Harold Iselin, Esq. of Greenberg Traurig was again retained by the New York State Bar Association to, among other things, assist the Elder Law Section in its lobbying efforts to oppose Governor Pataki's Medicaid provisions as contained in the 2005-2006 budget bill. In addition, numerous members of the Executive Committee met with legislators in an effort to educate them regarding the Medicaid program and the impact that adoption of these proposals would have on New York's elderly and disabled population. On April 12, for the second time in as many years, the restrictive Medicaid eligibility proposals did not make it into the final budget bill adopted by the legislature and signed by Governor Pataki. We owe a great deal of thanks to

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Daniel G. Fish
Incoming Chair

I am a lucky man. It is easy to start the term with a state budget already in place, restrictive Medicaid eligibility rules defeated, the Section recognized as a respected voice in the debate over health care spending, and the need for all New Yorkers to sign a health care proxy acknowledged. I am fortunate that the Section is in such a strong position. This is due in great part to the enormous efforts of Howard S. Krooks. He has devoted his complete attention to the Elder Law Section and the State Bar Association as well. He has served this Section well and we have all benefited from his leadership.

The role of the chair is to make the Section relevant to the lives of the members; to make it so that all of the elder law attorneys in New York feel that they cannot practice effectively without being a member of the Section. The Section must address the changes in substantive law and office management issues as well. It must present programs that cannot be missed. It must deliver publications by e-mail and hard copy

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Inside this Issue

Harold Iselin, Ronald Kennedy, Associate Director, Department of Governmental Relations, Ken Standard, President of the New York State Bar Association, A. Vincent Buzard, President-Elect of the New York State Bar Association, and the entire Executive Committee of NYSBA, all of whom recognized the significant role that the Association and the Elder Law Section could play in opposing the Governor's proposals. We also continue to work with the legislature and the Governor's office in developing the Compact proposal, which I will expand upon later in this message.

2. **Establish Regular Communication between the Section and Outside Groups**—the Section communicated with AARP in connection with Governor Pataki's Medicaid proposals and worked with AARP in connection with the Kincare Coalition, which was established by AARP to assure grandparent caregivers of certain rights when caring for minor children. In addition, the Section worked with NYSARC and the Greater Upstate Law Project ("GULP") in opposing an item contained in the New York State Department of Health's Regulatory Agenda dated June 30, 2004, wherein the Department of Health proposed to "count as income, in-kind income received in food, clothing and shelter rather than in cash." This would have represented a significant change in state policy reflected in 18 N.Y.C.R.R. 360-4.3(3), which currently provides that "in-kind income received from anyone *other than a legally responsible relative* is considered available income only if it is earned income. . . ." Had the state adopted this proposed change, third-party contributions for food, clothing and shelter items would have become countable income for Medicaid purposes. Thanks to the efforts of many organizations, this proposal is no longer being considered by the Department of Health.

3. **Establish Regular Communication within the Section**—six issues of the *e-News* were e-mailed to Section members throughout the year, keeping Section members up-to-date regarding recent cases decided by the courts, legislative activity, committee activities, and upcoming Elder Law Section programming. The Elder Law Section e-News (Steve Rondos, Chair, Dean Bress, Vice-Chair) was well-received and is being considered by other NYSBA sections as a means to communicate with their members.

4. **Identify Future Leadership**—The Leadership Task Force (Vincent Russo, Chair) created a memorandum outlining efforts the Section could make to identify future leaders. In addition, workshops were held at the Summer, Fall and Annual Meetings at which attendees could learn how to become more involved in Section activities and to become future leaders of the Section. This concept will be continued at future Section meetings under the stewardship of Michael Amoruso.

We have taken great measures toward achieving each one of these objectives. We also submitted formal positions with respect to several Trusts and Estates Law Section proposals, a response to a guardianship report issued by the Appellate Division, Second Department, and we took a leading role in submitting an alternative set of resolutions in connection with the Association's consideration of a formal policy regarding same-sex couples. But, we must not rest—not even for a moment. The landscape is changing at lightning speed and there is still much work to be done. On March 21, Senator Martin Golden sponsored S.3530, a bill based on the Compact proposal contained in the Section's Long Term Care Reform Report (as adopted by the Executive Committee at the January 25, 2005 Meeting). As I write this message in early May, a working group consisting of Michael Amoruso, Howard Angione, Daniel Fish, Gail Holubinka, Howard Krooks, Lou Pierro and Vincent Russo is working feverishly to develop the Compact proposal. The Senate is very interested in moving this proposal along and Governor Pataki's office is aware that the proposal is being developed. You may learn more about the Compact proposal at the Section's Summer Meeting, where Gail Holubinka, Vice-President, Med-America Insurance Company of New York, the brainchild of the Compact, will be making a presentation about the Compact. Also, you may review the proposal as originally published in the Section's Long Term Care Reform Report, which can be accessed on the Section's website.

On April 28, 2005, the Executive Committee met and considered a number of new projects that the Section has undertaken. I have formed a working group to address whether the Section should support the passage of a living will statute (Stephen Silverberg, Amy O'Connor, Co-Chairs). I have also appointed a working group to comment on proposed

changes to the power of attorney form that are being made by the Law Revision Commission (Robert Kruger, Chair). Finally, I have formed a working group to address issues raised by Assembly Bill A.1238, which proposes to amend the public health law to provide rights to domestic partners, spouses, parents, siblings and court-appointed administrators to control the disposition of a decedent's remains in the absence of written directions provided by the decedent (Michel Haggerty, Chair). Please contact the respective Chairs of these working groups should you have an interest in participating in formulating the Section's position on these issues.

I wish to thank the Officers (Joan Robert, Immediate Past Chair, Daniel Fish, Chair-Elect, Lawrence Davidow, Vice-Chair, Ellen Makofksy, Secretary, and Ami Longstreet, Treasurer) and the Executive Committee for their hard work and dedication throughout my term as Chair. It is a cliché but so true that I couldn't have done it without each and every one of you. I want to acknowledge the contributions made by Joan Robert and Daniel Fish, who were especially helpful to me during my term, providing valuable advice and guidance throughout the year. I also wish to thank Lisa Bataille, our staff liaison to the New York State Bar Association. Lisa is an unsung hero in my view who deserves all the accolades in the world for making the Elder Law Section a seamless operation. Kathy Heider in the Meetings Department at NYSBA has also done a tremendous job on Section programming. Finally, I wish to thank my family and law partners for their patience and understanding throughout the past year.

Our next meeting will be our Summer Meeting, to be held at the Boston Marriott Longwharf in Boston, Massachusetts from August 11-14, 2005. In addition to Gail Holubinka, who will address the Compact proposal, the program will feature speakers with national reputations, such as Natalie Choate and Alexander Bove.

Let me close by saying that we have much to be proud of as a New York State Bar Association Section. Full of legal talent, and energetic people who thanklessly and enthusiastically give of themselves and their time, we have developed into one of the Association's premier Sections. On the national level, we are recognized as one of the most active and effective elder law sections. We are admired for our dedication, our tireless energy, our creative thinking, innovative approaches to problem solving, our educational programming, and our leadership. While I realize the self-laudatory nature of these remarks, I think it is vitally important that we take a moment to recognize how far we have come in the fifteen years that we have been a Section. We have become an organization that is recognized by various agencies and non-profit groups and we have become a respected organization within the New York State Legislature, the Governor's office, and nursing home and other health care-related industry groups. We have become proactive in our efforts to work with these various organizations and groups, rather than simply reacting to proposed changes after the fact. There will be many opportunities in the coming months and years to build on these relationships, to enhance our standing in the community and to shape public policy. I am confident that our leadership, under the guidance of Chair Daniel G. Fish, a past President of the National Academy of Elder Law Attorneys and a fixture in the elder law community for over two decades, and our current slate of officers, will continue in the path that we have traveled. Given what we have accomplished so far, I eagerly await the future.

I have a deep fondness for the NYSBA Elder Law Section. It has been my pleasure and a great honor to serve as Section Chair.

I wish you all the best.

Howard S. Krooks

Editor's Message

The theme pieces of this edition of the *Elder Law Attorney* primarily address legislative reform both at the state and national level. The first article was written by Bernie Krooks and addresses the changes to long-term care insurance that were enacted as part of last year's budget. The next piece is by Anthony Enea who discusses the recent attempts by Governor Pataki to reform Medicaid law within New York State. We have a fascinating piece by Scott Solkoff informing us on the state of Medicaid reform in Florida. In addition, we have a piece by the National Academy of Elder Law Attorneys.

We have added a new column: "A View from the Bench." Our first contributor is Acting County Court Judge, Joel K. Asarch. In addition, we have continued with our legislative Op Ed column. The contributor for this issue is John F. Cape, who is the Governor's budget director.

With respect to our regular columns, we have added a column entitled "Pearls and Gems" that will be shared by David Goldfarb, Ronald A. Fatoullah, and Matthew Nolfo.

Finally, we have two bonus news pieces: The first was submitted by Section member Marc Crawford Leavitt on the topic of dental health for seniors. The second bonus news piece was written by Robert W. Ottinger, a practitioner in Manhattan, and gives some helpful advice on employment practices.

I would like to thank the Board of Editors for their assistance with this issue. We have added one additional member to the Board of Editors, Brian Andrew Tully.

Steven M. Ratner

Incoming Chair's Message *(Continued from page 1)*

that are so timely that they are read the moment they arrive. It must make a listserve available that is like another partner in the firm.

Relevance is the highest among members who are active and involved rather than passive. The best way to encourage involvement is to be transparent. The process of the Section selection of committee chairs and other positions of importance should be open and understandable to all those who want to participate. The role of the chair is not to do it all herself or himself. The real role is to find and allow others to become involved in the Section. There is a very valuable pool of talented attorneys who want to serve the Section and are looking for ways to become involved.

There are an equal number of opportunities for those interested in working within the Section. There are 33 standing committees, ranging from elder law practice, family law issues, guardianships, financial planning, technology, legal education, and Medicaid legislation to consumer issues, real estate, persons under disability, tax planning, and litigation. There is a place within the committee structure for every member of the Section who has a particular interest within the field of elder law. There are liaisons to other sections such as trusts and estates, public agencies, the judiciary, legal services, and law schools. There are representatives from the various districts. There are members at large. There are speakers needed for the various meetings. There are writers needed for the *Elder Law Attorney*.

The beginning of the term as chair is filled with conflicting emotions. There is a sense of elation at the ability to follow in the footsteps of the distinguished predecessors. There is also the sense of awe at the enormous responsibility, knowing that there are rogue waves in the form of legislation or court decisions or public events during the year that could capsize the ship. I invite you to join the voyage with me and to communicate with me and to serve the Section in whatever capacity suits you best.

A special thank you to Howard's family for the many sacrifices they have made over the last year. Robin Krooks has been a very understanding spouse despite the almost continuous conference calls. And I hope that Gavin, Jocelyn and Noah read this many years from now and take pride in their father's accomplishments.

Dan Fish

Long-Term Care Insurance: Changes on the Horizon

By Bernard A. Krooks

Last year, Governor Pataki introduced a budget bill which proposed significant changes to the Medicaid eligibility rules in New York. The "Medicaid reform" bill provided for: a) the extension of the Medicaid look-back period from 36 to 60 months; b) the imposition of a penalty period for Medicaid home care benefits; c) the elimination of spousal refusal in home care cases (and in nursing home cases, except for very limited exceptions); and d) the commencement of the Medicaid penalty period on the date of application rather than the month following the date of the asset transfer. The State Assembly and Senate rejected Governor Pataki's Medicaid reform bill. Instead, a final budget bill was signed into law containing several provisions intended to promote the purchase of long-term care insurance.

This year, the Governor proposed the same Medicaid reform bill as last year but also included changes designed to centralize the administration of spousal recovery actions, along with technical corrections to certain provisions in last year's bill regarding changes to the Partnership policies. The Governor's proposals were rejected by the legislature again this year; however, the technical corrections to the Partnership policies were adopted.

This article focuses on the long-term care insurance provisions, as technically corrected, which were enacted last year.

Increase New York State Income Tax Credit. First, and probably most significant, the New York state tax credit for premiums paid for qualified long-term care insurance was increased from 10% to 20%. Unlike federal law (which allows for a very limited deduction in only certain situations), New York State allows for a dollar-for-dollar credit against the taxpayer's New York State income tax liability. Although last year's budget bill was not adopted until the Fall of 2004, this increase in the credit applies to all New York State income tax returns filed for the 2004 tax year, and thereafter.

Creation of a Long-Term Care Insurance Education and Outreach Program. This program is to be established within the Department of Health for the purpose of informing and educating the general public about long-term care insurance, including Partnership policies. The Long-Term Care Insurance Education and Outreach Program must, at a minimum, consist of the following elements which will be provided by the Office for the Aging: a) educational and informational materials in print, audio, visual, electronic or other media; b) public service announcements, advertisements, media campaigns, workshops, mass mailings, conferences or presentations; c) establishment of a toll-free telephone hotline and electronic services to provide information; and d) establishment of long-term care insurance resource centers within each area agency on aging.

Creation of Long-Term Care Resource Centers. These centers are designed to provide direct assistance to the general public in choosing and obtaining long-term care insurance. Each long-term care insurance resource center is responsible for its own staffing and must submit an annual service plan and proposed budget to the state program coordinator for approval. At a minimum, each center must provide the general public with the following items and services: a) educational and informational materials in print, audio, visual, electronic or other media; b) public service announcements, advertisements, media campaigns, workshops, mass mailings, conferences or presentations; and c) counseling, information, referral services, and direct assistance in choosing and obtaining long-term care insurance. Direct assistance includes, but is not limited to, assistance with planning for the financing of long-term care, understanding policy options, benefits and appeal rights, obtaining the coverage needed and the appropriate benefits, and avoiding or reporting illegal billing, fraudulent practices or scams.

Reporting Requirements. The Commissioner of Health, the Director of the Office for Aging and the Superintendent of Insurance are required to file annual reports with the Governor, the Speaker of the Assembly, and the President of the Senate regarding the use of long-term care insurance in New York. The annual report shall contain, at a minimum, the fol-

lowing information: a) the number of individuals who have received counseling and assistance by the long-term care insurance education and outreach program; b) their ages and their occupations; c) whether these individuals have purchased a long-term care insurance policy and, if so, the type of policy purchased; d) a description of all the services, including counseling, education and outreach services, being provided by the long-term care education and outreach program, broken down by county; e) the activities used to promote the Partnership for long-term care program; and f) a description of the long-term care education and outreach program's funding sources and whether they are adequate. The report must also contain recommendations for targeting specific age groups to buy long-term care insurance, creating new methods of promoting the purchase of long-term care insurance, and improving long-term care insurance products.

Partnership Policies. The final budget bill made numerous changes to the Partnership program in an effort to make it more attractive to potential long-term care insurance buyers. A new type of Partnership policy (similar to the program that presently exists in Connecticut) will be offered, providing asset protection in an amount equal to the value of the benefits received under the Partnership policy. As technically corrected, these types of policies may be offered with a minimum of 12 months of benefits as opposed to 36 months for conventional Partnership policies. Additionally, the Commissioner of Health, in consultation with the Superintendent of Insurance and the director of the budget, may enter into agreements with other states that administer partnership for long-term care programs to provide for reciprocity of benefits. The purchasers of policies in those states with comparable benefits to policies available in New York will be eligible for Medicaid coverage in New York so long as purchasers of policies in New York with comparable benefits to policies available in such state(s) are eligible for Medicaid coverage in such state(s). Under prior law, Medicaid benefits under the Partnership program had to be received in New York State.

Notification Requirement. Insurance companies are required to permit policyholders to designate a third party to receive notices of nonpayment of premiums. It is hoped that this will help prevent policies from lapsing if the policyholder is incapacitated or forgets to make timely premium payments.

Investment Product Options. The New York State Insurance Department is directed to study and develop investment product options for insurance policyholders to adequately prepare for the costs of long-term care and related insurance products. For example, such study should include, at a minimum, the following concepts: a) combining long-term care insurance and disability insurance into an integrated product that will reduce the costs of each type of insurance; b) encouraging insurance companies to offer more products that contain a "living benefit" life insurance policy, which could then be used to pay for long-term care, including long-term care insurance premiums; c) allowing the insured access to life insurance benefits which could be used to pay for premiums on a long-term care insurance policy; d) allowing tax credits or deductions for long-term care insurance purchases for persons other than the insured; and e) developing strategies to reduce the potential for a lapse of insurance coverage due to an insured's inability to pay the premium, such as providing ascending tax benefits based on the amount of time the coverage is in force or working with insurance companies to offer paid-up premium plans.

Our New York State legislature is to be commended for recognizing the need for consumers to plan in advance for their long-term care. Encouraging the purchase of long-term care insurance is a step in the right direction. We anxiously await the insurance industry response to these provisions as new products are introduced into the marketplace.

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New York Medicaid Reform: The 2005-2006 Budget

By Anthony J. Enea

At the time of my writing this article, for the first time in 21 years the New York State Legislature passed the state budget by the April 1st deadline. The budget now awaits the signature of the Governor. However, there still remains some concern that the Governor may veto hundreds of millions of dollars of spending the Legislature added to his proposed budget, and that a battle could still loom as to Medicaid spending.

Fortunately, the changes and cuts to the Medicaid program that were originally proposed by the Governor in his 2005-2006 budget bill appear to have not been enacted. In brief, the proposals contained in the Governor's 2005-2006 budget relevant to Medicaid were as follows:

1. Increase the look-back period from 36 months to 60 months for both institutionalized and non-institutionalized spouses;
2. Commence the period of ineligibility/penalty period for non-exempt transfer of assets on the date the application for Medicaid is made, rather than on the first of the month following the date of transfer;
3. Authorize the imposition of a period of ineligibility/penalty period for Community Medicaid services such as home health services, personal care services, assisted living programs and other services which are determined to be "long term care services";
4. Elimination of Spousal Refusal in nursing home cases except where "undue hardship" can be established by the non-institutionalized spouse;
5. Elimination of Spousal Refusal in home care cases, i.e., Lombardi Program, except where the spouse is absent and refuses to make his or her income/resources available for the cost of care.

Additionally, there was a proposal to provide Medicaid with the authority to seek the assistance of the attorney general of the state of New York in prosecuting spousal recovery actions.

Obviously, if the above-stated proposals were enacted, the effect would have been devastating for seniors. Fortunately, and in no small part as a result of the efforts of the leadership of our Section, it appears that we have been able to stave off for at least another year some drastic changes to Medicaid. However, we should not be lulled into thinking that Medicaid reform will not be an ongoing topic of discussion both in the state legislature and federally.

"Fortunately, and in no small part as a result of the efforts of the leadership of our Section, it appears that we have been able to stave off for at least another year some drastic changes to Medicaid."

In brief, the major provisions in the 2005-2006 budget that were passed by the Legislature relevant to the Medicaid program are as follows:

A. Medicaid Cap: The state will take over/assume the local Medicaid costs, if said costs exceed an annual growth rate for costs that has been established by the state, which is, for 2006, 3.5%, 3.25% in 2007 and 3% in subsequent years.

In exchange for the state takeover, the counties are required to remit a set level of local revenue to the state, and will be subject to new accountability standards aimed at eliminating excessive local spending growth.

Commencing in 2008, the counties will have two contribution options to choose from: (a) they can choose to remit to the state an amount equal to the capped spending plus 3% annual growth, or (b) remit a fixed percentage of their sales tax revenue equal to the state's fiscal year 2006-2007 capped contribution.

B. Effective October 1, 2005, the state will take over all Family Health Plus Programs outside of New York City from the counties. It is estimated that the Medicaid Cap and takeover of Family Health Plus Programs will save local taxpayers $3.3 billion annually when fully effective.

Thus, it appears that the state takeover of local Medicaid costs has begun. Whether or not this is only the tip of the Medicaid Reform iceberg remains to be seen. For the fiscal year 2005-2006, it appears safe to say we have survived to fight another day.

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

Florida Medicaid Reform

By Scott M. Solkoff

(The following is a letter sent by Mr. Solkoff to members of the Florida Bar Elder Law Section.)

Dear Colleagues:

I have written this from Tallahassee with important news. On Wednesday, March 9th, at a meeting at a very high level in government, I was told that the State is contemplating criminal and/or civil prosecutions against Elder Law Attorneys. If you are on the Elder Law listserve, you should already have received an announcement from the Public Policy Task Force but the purpose of this letter is to share with you the facts and circumstances of that meeting and to then share with you the Elder Law Section's plan and actions. I apologize in advance for the lengthy and sometimes roaming nature of this letter but I feel you need to know all that occurred at that meeting. It is my hope here to inform you and not to unnecessarily create anxiety.

On Tuesday, I received a call from the office of Florida Bar President Kelly Overstreet Johnson. I was told that the President had been summoned to a meeting being held by the Agency for Health Care Administration (AHCA) regarding "Medicaid Planning" and would I and Lauchlin be able to accompany her. Neither the President nor I were informed as to the purpose of the meeting, only that it would be held in the Attorney General's conference room. To understand this in context, you must also know that the Elder Law Section has been very active at both the legislative and agency level in the course of the Medicaid "reform" effort currently underway. I asked Lauchlin Waldoch, Co-Chair of the Joint Public Policy Task Force (a public policy project of the Elder Law Section and the Academy of Florida Elder Law Attorneys (AFELA)), and Tom Bachelor, the Section's Public Policy Consultant, to join me and the President.

As the participants started arriving, the first business card I was handed had the Attorney General job title, "Director, Medicaid Fraud Control Unit." We were joined by the Secretary of AHCA, the Acting Secretary of DOEA, the Deputy Chief of Staff to the Governor, the Inspector General of AHCA, the Deputy Florida Attorney General and senior staff to these officials.

The meeting started off with the Attorney General people telling us that the Governor has made Medicaid reform a top priority and that it would be unseemly for the government to be going about fixing the Medicaid program while Elder Law Attorneys were out there "qualifying millionaires for Medicaid." The Deputy Attorney General then directly informed us that they are considering criminal prosecutions against attorneys who assist people to shelter their assets to help qualify for Medicaid. The Medicaid Fraud A.G., and the Deputy A.G., told us that they are specifically contemplating criminal fraud prosecutions. They explained that the Governor himself was personally aware of the "Medicaid planning problem" and that it must stop. The Secretary of AHCA reiterated the threat of prosecution and explained how his agency was ready to be a part of this new prosecution solution. These were not veiled threats but were very direct. These government officials looked me in the eye and told me that they would like to make an example of someone. After about ten minutes of these threats, I was given the opportunity to speak.

I explained that as Chair of the Florida Bar's Elder Law Section, I represent 1700 Elder Law Attorneys in Florida, some of whom, it is true, legally help people qualify for Medicaid. I explained that we help people save needed funds so they can pay for everything Medicaid will not currently cover. I gave examples. God (or you all) were with me. With all my nerves, I became the most eloquent I think I have ever been. I spoke passionately on how our clients saved and saved and saved for their retirement only to be beaned by a long-term care system that demands an average of $6,000 per month for one person in a semi-private room in an average nursing home. I explained why we do what we do. I explained that there are many services neither Medicaid nor Medicare will cover and that supplemental funds are necessary in a system that is incomplete at

best. I gave specific examples. I admitted that there are fringe actors who push the system to legal but unethical extremes but that we should not make the masses suffer for the sins of the few. I suggested that there are many other methods by which the State can save money and that we would be very willing to be a part of that remedy. I spoke about specific planning options and why they are and should remain legal but how there are other strategies which should probably be reexamined and that we want to be a part of the solution, not their problem. I said that I resented myself and my peers being painted as criminals and that we are law abiding attorneys helping desperate seniors with desperate problems. When challenged by the Secretary of AHCA who said that all necessary services are covered, I explained that this was wrong. I told how dentures, significant physical therapy, eyeglasses and supplemental attendant care was absolutely not provided. I explained that when seniors are forced to spend down to the $2,000 asset cap, they have nothing left to pay for all the things the government will not cover. I congratulated them on trying to fix "the problem," but explained that the "problem" of Medicaid Planning was necessarily developed as a solution to the much bigger problem of a broken long-term care system which impoverishes good taxpayers. I explained that if they were to fix the "problem" of Medicaid Planning without fixing the bigger problem of access and affordability of care, that they will be, by their own "good intentions," causing catastrophic harm.

There was a change in the mood of the room when I finished. While their positions did not change, I believe that some of them recognized that there was another side to the issue, one with which even if they disagreed would still be a potent weapon against their position of demonizing attorneys for the elderly. The dynamic had turned from one of confrontation and threats to one of dialogue.

To my delight, Lauchlin and Tom were given the opportunity to speak. Lauchlin spoke about specific areas where we may be able to provide technical assistance in fixing some of the budgetary problems. Lauchlin flat out confronted the criminal prosecution issue by saying that it was improper and not legally possible to prosecute any attorney for advising a client on perfectly legal planning opportunities. The participants were very interested in the estate recovery issues and seemed to be receptive to Lauchlin's point that they should enforce existing laws and try to fix a broken system rather than going after attorneys for the elderly. Lauchlin's respectful but firm style and presence was absolutely felt in the room.

Kelly Overstreet Johnson defended us. When asked what The Florida Bar would do, she told the group that she opposes any attempt to stifle a lawyer giving legal advice to any client. They asked her whether there was anything the Bar could do from an ethics or lawyer regulation standpoint. President Johnson said that it was not unethical to counsel clients as to their legal rights and that the Bar would not be looking to discipline attorneys for so counseling our clients. The President explained that the Bar is capable and willing, through the Elder Law Section, to provide technical guidance and other support to help fix bad laws but that the Bar would stand by the right of a client to gain legal counsel.

The Governor's Chief of Staff held up a print-out from a website about Medicaid planning and indicated how egregious an example of immoral lawyering that is. I pointed out that it was probably from an insurance agent and not one of our folks. This turned out to be true and it led the discussion away from "bad lawyers" to bad annuity agents who hawk Medicaid Planning services. Lauchlin and I explained how there are abuses of annuities and that there are many elderly victims of inappropriate annuity sales done under the guise of Medicaid Planning. This then led to questions to President Overstreet about pursuing these bad actors for the unlicensed practice of law. The President said this could, should and would be examined by the Bar.

During this period of open discussion, there were some good signs. On more than one occasion, the inference and then the direct invitation was made to help AHCA with policy and implementation. The Elder Law Section has always viewed such invitations as a good thing; better to be at the table and helping to guide the process than to be surprised with bad, uninformed results.

Despite headway in creating dialogue from threats, in closing the meeting, the A.G.'s office brought up criminal prosecution again. Lauchlin, the President and I, replied that this was a noxious and inappropriate charge against law-abiding lawyers. When I asked how they determined what would be deemed fraud and what was legal, the Medicaid Fraud Control Unit Director and the Deputy Attorney General said that there was no bright line. I explained

that if their object was for me to go back to the membership and tell everyone what we should not be doing, that I would need something more. They talked about the $4 Million dollar cases. They talked about going after the lawyers who are qualifying rich people for Medicaid. I asked if there was a dollar amount. How much would be too much? Is the same planning option okay when a person has $75,000 as when the client has $2,000,000? Lauchlin and I explained how one client may ethically require one sum of money to supplement care while another client may require much more. A 63-year-old dementia patient may well require six figures or more in supplemental services whereas a 92-year-old patient would require something less. They would not be nailed down because, of course, there could be no science or rational basis to this. They did say that when they went after doctors for Medicaid fraud and were asked the same questions about where the line is drawn (e.g., how many patients is it okay to have on hospice beyond the six months), they did not attempt to create a bright line. They explained how they instead selected cases they felt were egregious and made examples of them and that they planned to do the same here. The A.G. people said that even if criminal fraud does not fly, that false claims would provide another possible route of prosecution and if that did not work that there would be civil remedies.

The meeting ended much more cordially and respectfully than it began but you will note that the meeting both began and ended with direct threats of prosecution. We remained indignant to the end that it is a travesty to suggest that advising clients about their legal rights is in any way actionable.

Though it was never said, I know they want me to have to write this letter to you. That may have been a primary goal of the whole meeting. They may believe this will have a chilling effect on Medicaid planning and they are probably right. There are some members who will make the decision that they do not want to risk prosecution. There are others who will continue to assist their clients with no change in practice. I cannot advise you on what you should do. That is a personal decision you yourself must make based on your own ethical, legal and business analysis of these facts.

It is possible that no prosecutions will take place. I have been very busy here in Tallahassee and have talked with many people whose opinions I respect. There are some who believe this to have been an attempt at intimidation and that there is no actual imminent threat of prosecution. There are some who have analyzed the meeting from an informed political perspective who believe that this is "business as usual" in this town. There are some who believe that this is a real threat and that we must prepare to defend our clients and our members.

I remain optimistic in many ways. I think the people in that room are good people who had only part of the story when they planned how that meeting would be conducted. If all you knew of "Medicaid planning" was primarily from a *Wall Street Journal* op-ed piece, you too might have jumped to the wrong conclusions. Now they know more. Also, hidden within this very real challenge is very real opportunity. We may be able to influence policy more directly than ever before. Also, our planning has never been more publicly debated and we win the argument when people are given more information than just the misleading sound-bite of "millionaires on Medicaid." On the other hand, I think it would be dangerous to underestimate these people, their convictions and their power. We must prepare as if they meant what they said. Accordingly, I have asked for and received the full support of Elder Law Section leadership that we devote all available resources to this effort and that we seek out new resources where those are needed.

I recognize that while fear, anger and anxiety will only begin to explain your emotions in reading this letter, it is important that we not overreact. Our collective reaction to what I am sharing with you must be thoughtful and deliberate. I also do not want to run the danger of downplaying what occurred. The fact is that Elder Law Attorneys were directly threatened with criminal and civil prosecution and not by some lower-level prosecutor with a project but by the highest level of government.

Here is what is being done and what has been done:

- We already have hired a Public Policy Consultant, Tom Bachelor, who has been immeasurably helpful. Tom has been working with the Section going on three years now and his work over the past month has been especially notable.
- Last year, knowing we had significant challenges on the horizon, I worked with the leadership of AFELA, most notably AFELA President, Ed Boyer, to create the new Joint Public Policy Task Force chaired by Julie Osterhout

and Lauchlin Waldoch. This Task Force has amassed a very high level of old and new talent to analyze legislation, to help determine public policy and to interface directly with Tom Bachelor.

- Last year, the Public Policy Task Force selected legal counsel to help in the fight against new agency regulations. Leadership is now in at least weekly contact with Attorney Bruce McKibben. Within the past six months, Bruce (and Tom) has helped us to successfully defeat bad agency rules.
- With AFELA, we have raised money in direct contributions from members like you for the purpose of public policy advocacy and defense.
- We have consulted with and received a commitment of support from the National Academy of Elder Law Attorneys. We have been given some access to their public relations company and have had some benefit of their input. We have consulted with NAELA's national Public Policy Consultant, Brian Lindberg, and he has now joined our Task Force calls.
- We have reached out to other state and national organizations to forge mutually beneficial relationships.
- We have developed a protocol to quickly respond to relevant governmental affairs and we have become proactive on some fronts.
- We are contemplating the immediate hiring of specialized lobbyists whom we believe can be an asset on the issues covered in this letter and other matters pending before the legislature and agencies.
- We are developing plans on how to respond if and when one of us is prosecuted. We believe that if a lawyer is prosecuted, that they will select what they perceive to be an egregious example. They may go after a lawyer who handled a higher net-worth client or they may go after lawyers based on volume. The first case may be one that some see as unethical and which some of us may cringe at but which is nonetheless legal. We are determining whether and how we can come to an attorney's aid.

There are many more things that are going on and I am not able to cover them all here. I cannot overstate the contribution that leadership is making all with no compensation and even little reimbursement. I have lost many unrecoverable dollars in revenue to my firm. I have been away from my family too much. I have had to skip out of town at a moment's notice and cancel all of my meetings for multiple days. I am trying my very best to do my very best for all of us. The sacrifice I am making is small compared to some others. I am not going to mention all of their names here but suffice it to say that the Task Force members and their "go to" people have put in hundreds of hours. I am not saying all of this to get your calls of thanks or sympathy. I am telling you all this because it is time to pony up.

If we are going to fight this battle, it will be expensive. Look at all the priorities detailed above and start adding up the costs to do it right. Lauchlin, Scott, Ed, Julie and other Task Force members are full time attorneys with families and practices and we cannot do it all. Even if we somehow could carve out more time, we are admittedly in over our heads at this point. We need to pay professionals just like our clients come to us when they need help. If we are going to fight this battle, we need to rachet up the budget for professional assistance. We do not have enough money to fight this battle, let alone win it. I believe it is winnable. I would like to be able to say that we have plenty of money to defend Elder Law Attorneys who are unjustly accused of fraud. I would like to be able to list many more accomplishments and objectives. I have a whole wish list. The fact is that we need our members to step up to the plate. Now is past the time. If you have not given before, please consider how much you can give. If you have given before or if you have already committed, please consider whether there is room for you to do more. We have the infrastructure but we need more horses. There is no way that leadership alone can underwrite this effort. If we do not get help from the members, this will be a non-starter and we will fail. With member support, I believe we will not only retain this practice area but will end up being more effective lawyers and advocates.

You will shortly receive a contribution form and instruction. Please give generously. Whether or not you engage in Medicaid Planning, this is your client base that is being denied the right to counsel. You should not doubt our collective ability to effect change. For those who have been following the reports of the Public Policy Task Force, you know how incredibly successful we have been in our efforts to date.

Before I close, I want to make one point which I believe to be very important. Many of you have been helping the frail elderly legally protect their savings so that they would not be wiped out by ruinously expensive long-term care. You have believed that what you do is not only legal but morally and ethically just. You have never thought yourself to be operating at the fringes of law and morality. You have been practicing in a field that now goes back decades, which has state and national organizations of legitimacy and regard. Now some of the highest officials in your government have called your work criminal or actionable.

This can be confusing to some. It may cause some to question their own moral compass and to have some loss of self-respect or pride. Do not let that happen. You know why you do what you do. You know that your clients saved and saved and saved for retirement and that they are now getting skewered in a long-term care system run amuck; that the client who saved is paying $6,000 a month in a nursing home and going through the money fast while the person who lived the Life of Riley is in the next room receiving the same care on Medicaid. The system penalizes savings because the savers do not get the benefit of their money without planning. You know that if your client was unlucky enough to contract Alzheimer's Disease instead of lung cancer, that there is no ability to pay for that care other than through Medicaid and with still the need for supplemental funds. We do what we do because it improves quality of life and because more care saves lives. If the government fixes the "problem" of Medicaid planning but does not fix the real problems of the inadequacy of the long-term care system, old people will suffer and some will die for lack of care. What you do in helping your clients protect their savings is noble and just. You are helping people each and every day.

We have a long-term care system that has spun out of control, well beyond most people's ability to pay. If people spend all of their money and then go on Medicaid, they will have nothing left to pay for all of the extras that will make a difference in quality of life and which sometimes can even save lives. Let us not forget that we do what we do not because our clients are greedy but because money buys care. We are not out to preserve inheritances. Our clients worked hard for their money and they deserve the benefit of their savings.

If you believe you could be a help in this effort, please contact Lauchlin, Julie, Ed and/or myself. As important and as necessary as it is, money is not all that matters in this effort. We need help with bill drafting, working up bills, developing procedure and other tasks. If you have legislative or agency contacts, please consider coordinating with the Public Policy Task Force before you testify at any hearings or meet with law makers but this could be a valuable contribution. Also, if you are approached by the press, please direct those inquiries to my office. We hope to have a PR team more fully integrated but for that we will have to see how much money is raised.

I hope you are okay after reading this letter and that you will channel any anxiety to your checkbook and advocacy. I can tell you quite frankly that we expect support from the membership and from other attorneys who may not even practice in this area but who believe in the right of lawyers to provide legal advice without the threat of criminal prosecution. Following this letter will come another letter from the Public Policy Task Force asking you to give and giving instruction on how to get your money to where it is needed.

For more information on legislative and agency action, please review the AFELA listserve announcements supplied by the Public Policy Task Force. If you are not on the AFELA listserve, contact AFELA at 850-656-8848. Future meetings of the Elder Law Section will continue to include public policy updates.

Very truly yours,

Scott M. Solkoff, Chair
The Florida Bar Elder Law Section

Correction

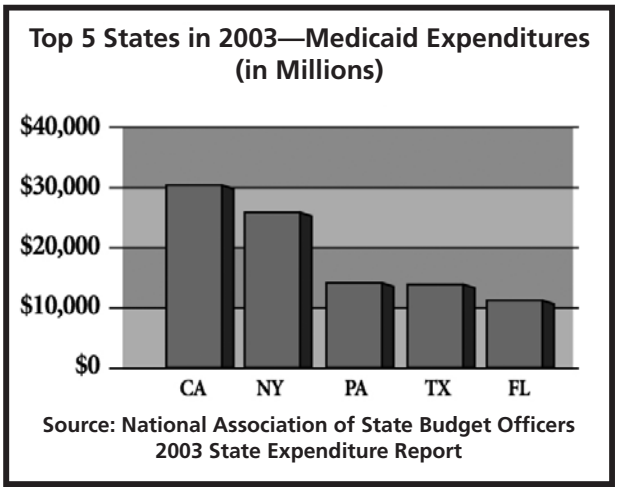
In error, the last Snowbird News column indicated that New York law requires three signatures on the self-proving affidavit. New York law requires only two signatures of attesting witnesses on the affidavit.

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

State and Federal Medicaid Reform Overview

By the National Academy of Elder Law Attorneys (NAELA)

Balancing State Budgets on the Backs of Our Elderly and Disabled



At their winter meeting earlier this week in Washington, DC, governors from across the country met with President Bush to discuss state issues, including Medicaid budget cuts proposed by the President. As a jointly funded venture between the Federal and State governments to assist states in providing adequate medical care to eligible needy persons, Medicaid is the largest program providing medical and health-related services to the elderly, disabled and blind.

No one would have thought that Medicaid funds for necessary medical treatments for our elderly and disabled populations would become pawns in balancing state budgets. What most people don't understand is that the federal government allocates a "pot" of Medicaid dollars to each state and then allows the state to administer the Medicaid program within specified guidelines. **States are allowed to apply for "waivers" to the program to allow for program expansions and ways to meet other policy goals. Thus, in what most of us consider a federal program, it is surprising to see that Medicaid benefits may actually fluctuate from state to state.**

Over the past 20 years the Centers for Medicare and Medicaid Services (CMS), has allowed and, even sometimes encouraged, states to experiment with the Medicaid Program. "Medicaid waivers" were originally conceived to allow the states to expand coverage and to experiment with the program to further certain public policy goals. For example, many states have Medicaid waiver programs which assist the elderly and disabled in staying in their own homes as this meets two public policy goals: the first to reduce the cost to the state by avoiding institutionalization, and the second to provide a higher degree of independence and quality of life for the disabled or elderly person. Similarly in 1992, Medicaid waivers were permitted for the purpose of encouraging the purchase of long term care insurance, although only four states were permitted to initiate this effort.

Recent Medicaid waivers proposed by the states of Connecticut, Massachusetts, New York, and Minnesota are not waivers that would expand coverage or provide for experimentation to achieve other public policy goals. **These waivers are intended solely for the purpose of reducing state expenditures by reducing Medicaid coverage or by restricting those who qualify for certain coverages. These state agencies are requesting permission from CMS to ignore federal statutory law relating to look-back periods for gifts, estate recoveries, lien processes, and other technical items that ultimately restrict the number of eligible Medicaid recipients in these states.** CMS has not yet approved any of these waivers; however, pressure is being placed upon the Administration to approve these "negative waivers."

The National Academy of Elder Law Attorneys (NAELA), whose members represent thousands of individuals in the affected states, has concerns with both the process and the policies themselves. NAELA believes it is in the best interest of our elderly and disabled citizens that Congress should control and govern significant public policy decisions when federal benefits are affected. Furthermore, state and federal bureaucracies should not be empowered to make substantive policy decisions that affect the health and welfare of our most vulnerable populations. The act of a state employee asking a federal employee to ignore an act of Congress is fundamentally flawed and leaves the elderly and disabled to the mercy of those who are simply looking to balance budgets and are not attuned to what the benefits were developed for or what they mean for our citizens.

Public policy concerns aside, the overall goal should not be to restrict coverage or reduce benefits, but rather to assist the states in their budgetary dilemmas. The states and federal government should first look to the very inefficient administrative processes within the Medicaid program itself. They should take a fresh approach to health care, in general, and the irrational patchwork of programs that have been implemented. Finally, policy makers must consider the likely unintended results, including significant shifts in social norms as our citizens are forced to desperately look for ways to work around the system.

"Until we address the real health care issues in our society and develop alternative ways of dealing with these problems, we cannot remove benefits from those who count on them and need them the most."

One of the core values of our country is to take care of our own citizens. We have programs in place, albeit, they are not ideal. Until we address the real health care issues in our society and develop alternative ways of dealing with these problems, we cannot remove benefits from those who count on them and need them the most. Balancing state budgets is a weak defense for not upholding our core values.

For more information about elder law attorneys and the National Academy of Elder Law Attorneys, visit http://www.naela.org. Established in 1987, NAELA provides a resource of information, education, networking and assistance to those who deal with the many specialized issues involved with legal services to the elderly and people with special needs.

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Note to Our Readers: *This e-newsletter,* ***Eye on Elder Issues****, is presented as a public service by the National Academy of Elder Law Attorneys (NAELA). This publication is intended to explore those issues from all sides and to educate consumers, aging network professionals, law makers, and members of the media.* ***Eye on Elder Issues*** *is for your free and unrestricted use; permission to reprint in whole or part is granted provided appropriate credit is given to NAELA.*

ELDER LAW NEWS

REGULAR COLUMNS

A View from the Bench

By Hon. Joel K. Asarch

> *The legislature declares that it is the purpose of this act to promote the public welfare by establishing a guardianship system which is appropriate to satisfy either personal or property management needs of an incapacitated person in a manner tailored to the individual needs of that person, which takes into account the personal wishes, preferences and desires of the person, and which affords the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person's life.*
>
> **Mental Hygiene Law (MHL) § 81.01**

A long, long time ago in a galaxy far, far away (sorry—a little too much of "Sith" fever), I practiced in the guardianship realm. I served as court evaluator, guardian, attorney and court examiner. In some cases, I received what I considered to be *de minimus* court-awarded fees; while in others, fair and reasonable compensation was awarded. With this background, I have "crossed over" and now sit in a guardianship part in Nassau County—far from the small claims ("but it's the principle of the thing, judge!") and arraignments of my previous abode.

When Joan Robert first asked me if I would wax poetic/philosophical in an article for the *Elder Law Attorney*, I reflected on what I, as a formerly practicing attorney, would have liked to have heard from a sitting judge on guardianship issues. I decided that some thoughts on practicing in the Article 81 realm in Nassau County might be of some use. If not, there are some wonderful articles elsewhere in this excellent publication (I know—I read it too). All I ask is for you to remember that these are the thoughts of only one person—other judges may think differently about a great many of these topics. So here goes.

Working with those individuals who can no longer take care of themselves is the most rewarding thing I have ever done. To sit and talk with a person who was brought up during the Depression, whose long-term memory is wonderful (even if his/her short-term memory is not) and who can tell stories about strolling along Eastern Parkway in Brooklyn in the 1930s is a privilege. The guardians who care for these incapacitated persons are the closest things we have to angels on earth. Yet, sometimes things go awry and the court must always keep vigilant.

Factors to Keep in Mind When Preparing the Petition—one must never lose sight of the fact that in the appointment of a guardian (or even a temporary guardian), a person is being deprived of control over some part(s) of his or her life. ["whatever the extent of a guardianship, it inevitably entails a deprivation of liberty and is therefore a legal proceeding of constitutional dimensions which entitles any prospective incapacitated person to constitutional due process protections," *In re Doe,* 181 Misc. 2d 787, 790, 696 N.Y.S.2d 384, 387 (Supreme Court Nassau County, 1999) (Rossetti, J.)]. Whether it is in financial decision making, or deciding what medical treatment (if any) to seek, the alleged incapacitated person ("the AIP") is being thrust into a situation where someone else is getting involved to make certain decisions. Obviously, there are situations where guardianship is essential for the health, safety and/or financial well-being of an AIP; however, we must always remember that the petitioner's burden of proof is by "clear and convincing" evidence, MHL § 81.12. No matter how much the judge as *parens patriae* might think that the AIP might benefit from the appointment of a guardian (temporary or otherwise), the petitioner must first meet his or her burden of proof. This starts with the drafting of the petition.

"To sit and talk with a person who was brought up during the Depression, whose long-term memory is wonderful (even if his/her short-term memory is not) . . . is a privilege.The guardians who care for these incapacitated persons are the closest things we have to angels on earth."

I discourage the use of social security numbers and full bank account numbers in the petition. While the recent changes to Article 81 have reduced the number of situations where the petition itself is being served (see MHL § 81.07(g) as amended effective December 13, 2004), the possibility still exists that this information is obtainable by third parties who may improperly utilize such information. Medical information is also an area where privacy concerns predominate (just read the HIPAA regulations). I do not require medical affidavits to be attached to or come in with the petition. However, where appropri-

ate and upon letter application on notice, I will authorize the court evaluator to retain an independent medical expert [MHL § 81.09(c)(7)]—or to inspect medical and other records of the AIP [MHL § 81.09(d)]. Whether all, some or none of this information is admissible at the hearing is a matter to be addressed on a case-by-case basis.

Note: this same caveat applies to an order to show cause to approve a contract for the sale for real property. Please remember that the papers are being served on third persons. Omit social security numbers of the buyer and seller from the contract of sale.

While the issue of standing to commence an Article 81 proceeding is not burdensome [MHL § 81.06], if the petitioner is neither a family member nor the administrator of a facility where the AIP is residing at the time the proceeding is commenced, the petition should clearly set forth how the petitioner is "concerned with the welfare of the person alleged to be incapacitated," MHL § 81.06(a)(6). I remember one case where I rejected (a/k/a declined to sign) an Order to Show Cause where the petitioner was a hospital administrator who was seeking to be paid and the AIP had been transferred to a non-related nursing home prior to the commencement of the proceeding. A resubmitted order to show cause and affidavit cured the deficiencies.

The Appointment Process—the Guardianship Clerk's office presents me with a proposed Order to Show Cause and petition. All court fees have been paid (index number and RJI—not an additional motion fee). When I read the petition, I look to see indicia of incapacity, the type of problems that are being presented (does the application concern seeking to make immediate medical decisions—i.e., for a biopsy or medical testing?), alleged waste of the person's funds (is this an intra-family fight or the nursing home seeking to be paid? Are funds being given to or taken away by home health aides?), is the spouse seeking a special guardianship for Medicaid planning?, etc. Each case presents unique issues and problems.

I examine the petition to see if temporary powers are being sought [MHL § 81.23(a)] or if a temporary restraining order is being applied for (is a foreclosure action threatened or has the house been recently transferred to a third party without consideration), MHL § 81.23(b). Is this a situation where the *status quo* should be maintained until a hearing can be held? Every case is different and every case is decided on its own merits.

Sometimes, I will charge the court evaluator to take such steps as are necessary to prevent "waste, misappropriation or loss" to property under MHL § 81.09(e) rather than appoint a temporary guardian. It is important to keep in mind that as more persons are appointed by the court, that more fees may be sought and awarded. Even the Mental Hygiene Legal Service has recently received a step up in compensation.

In almost all cases, I will appoint a court evaluator. I like having an independent third person investigate what is really going on in any case, to speak with all interested persons and to give the court his or her impressions and recommendations (whether the court ultimately agrees with them or not). While the court may dispense with the appointment of a court evaluator by appointing counsel for the AIP [MHL § 81.10(g)], the roles of the appointees are different. Counsel is an advocate for the client; the evaluator is an independent investigator. *See In re Lichtenstein*, 223 A.D.2d 309, 646 N.Y.S.2d 94 (1st Dep't 1996). If during the investigation, the court evaluator learns of a reason why counsel should be appointed [the AIP contests the petition, wishes the appointment of an attorney or any other factor under MHL § 81.10(c)], the evaluator contacts chambers and I issue an order appointing counsel forthwith. If the AIP wants to retain his/her own attorney, I will vacate the court appointment only after I am convinced that the AIP has freely chosen this attorney of his/her own free will, MHL § 81.10(a) as amended. I am concerned with family members choosing lawyers for the AIP. I do this at a hearing before proceeding with the merits of the guardianship application.

I, like all judges, appoint evaluators and counsel from the Part 36 list of fiduciaries, a few key strokes away under www.nycourts.gov. To the extent that I have cases where I need to make appointments, I will appoint any qualified person on the Part 36 list who lets me know by letter that they would like an appointment. However, in those cases that appear to be more complex or more contested, the most experienced fiduciaries will be selected from the list. This list is constantly changing because of the limits on appointments imposed by Part 36. Further, there are other cases where I turn to the experience and expertise of the Mental Hygiene Legal Service, either because the AIP is in a facility or, under a pilot project, is in the community but has no discernable assets.

It is at this point that I "mark up" the Order to Show Cause, striking any temporary powers that I believe are inappropriate or premature, setting a return date between 24 and 28 days from the date I sign the Order to Show Cause [MHL § 81.07(b)(1)], directing service on necessary and permissible parties, and making certain that the service directives comply with the amended MHL § 81.07(f) and (g).

The Hearing—MHL § 81.11(a) requires that a hearing be held on the issue of the appointment of a guardian. *See In re Eggleston*, 303 A.D.2d 263, 757 N.Y.S.2d 24 (1st Dep't 2003); *see also In re Department of Social Work of Beth Israel Medical Center (Panartos)*, 308 A.D.2d 350, 764 N.Y.S.2d 87 (1st Dep't 2003).

MHL § 81.07(b)(1) requires that the hearing take place no more than 28 days from the date of the signing of the Order to Show Cause, unless there is good cause shown to adjourn the hearing. I recognize that situations exist where adjournments are necessary. Generally, I permit one brief adjournment on consent. However, I always keep in mind that being the subject of a pending guardianship proceeding places a great deal of stress on an AIP. I have seen AIPs develop cardiac conditions during the pendency of an Article 81 (caused by the proceeding? Undetermined, but troubling nonetheless). Thereafter, I am less generous in granting adjournments, especially where, as in one case, the AIP was approaching triple digits in age. However, every case is different and requires being judged on its own facts.

The evening before the hearing, I sit down with the court's file and the court evaluator's report. When I make an appointment, I send a letter to the appointee, requesting that a copy of any written report be submitted/faxed to chambers prior to the hearing date. I refresh my recollection about the case by reading the petition and any supporting papers. I make certain that service has been made. If objections or cross-petitions have been filed, I review them.

On the day of the hearing, I will first conference the case with counsel and the evaluator. I can at this point determine if the AIP is consenting to the appointment of a guardian (at which point I can focus on whether the person has the ability to consent to the appointment and become a "person in need of a guardian" ["PING"] under MHL § 81.02(a)). If there is a contested proceeding, I can find out if the parties disagree over whether or not a guardian should be appointed or over who the guardian should be. It is at this conference that I find out if the AIP is present in court and if not, should I make what I refer to as a "field trip"? Since becoming a guardianship judge, I have seen just about every nursing home and assisted living facility in Nassau County (this is my own version of the slogan, "Join the Navy, see the world"). It is the exception when I will not see the AIP, see MHL § 81.11(c). Quite honestly, the most rewarding part of the work I do is to speak with the AIP.

Following the conference, I hold a hearing. Generally, I will speak with the AIP on the record, but not in the courtroom. I want that person to be able to speak without his/her relatives being there and without feeling intimidated by the courtroom atmosphere. I invite counsel to attend but to be "mute." This is the time where I can get my own impressions of the AIP and it also serves as a touchstone for the evaluator and his/her impressions. I will not speak with the AIP if s/he and/or counsel objects. Significant issues exist when the AIP declines to speak with the court or to take the stand. *See In re United Health Services Hospitals, Inc.*, 6 Misc. 3d 447, 785 N.Y.S.2d 313 (Supreme Court Broome County, 2004).

If counsel is not present, I will ask the AIP if he or she wants an attorney. MHL § 81.11(e). And then we simply talk. I look for any long-term or short-term memory deficits. I look to see if we repeat the same subjects. I try to see if the AIP recognizes that he or she has certain impairments or if s/he wants some help. I try to find out about the person today as opposed to previously. I recognize that people sometimes have "good days" and "bad days." I prefer speaking with AIPs in the morning to avoid "sundown syndrome." Does the AIP recognize the court evaluator or counsel? What does the AIP enjoy doing? A significant by-product of this interview is a determination as to what input the AIP should have in decision-making. In certain cases, based on my impressions, I will require the guardian to consult with the incapacitated person ["IP"]/PING before making certain decisions. In other situations, I may allow the IP/PING to have a checking account and pay certain bills (with guardian oversight). As I've said previously, each case is different and each case requires its own solution. However, the overriding concern of the court is the least restrictive form of intervention for the person who is now before the court.

After my interview with the AIP, I take the bench and hold a hearing. If the situation is one of consent by a person in need of a guardian, I try to avoid a prolonged hearing which would only embarrass or upset the AIP. In such circumstances, the petitioner must show that the AIP needs a guardian to provide for the "personal needs of that person, including food, clothing, shelter, health care, or safety and/or to manage the property and financial affairs of that person," MHL § 81.02(a)(1). I briefly hear from the court evaluator, whose report is in evidence if there is no objection.

If the standard is one of incapacity, I will hear from family members, social workers, and any other witnesses who can show "by clear and convincing proof" that the subject of the proceeding is incapacitated. Medical testimony is not the focus, see *In re*

Rosa B.S., 1 A.D.3d 355, 767 N.Y.S.2d 33 (2d Dep't 2003) and, in fact, the rules of evidence concerning the introduction of medical testimony apply.

Where the AIP objects to having a guardian appointed for him or her, the hearing is conducted like any other trial—the attorneys present the evidence and the court makes the evidentiary rulings and renders a decision. There is not enough space in this brief article to comment on the nuances in a contested hearing.

If I am requested to appoint a non-Part 36 person as guardian, I want to meet that person. Just as I want to form my own impressions concerning the capacity of the AIP, I want to see and hear from the person who will be in control of a great deal of the IP's life. Can that person make difficult decisions if that is what the IP desired when not incapacitated (i.e., as contained in a living will)? Is this person doing it out of love or prospective financial gain? Where there are co-guardians proposed, can the two individuals get along? I learned a long time ago that if two siblings say that they can get along but act like they cannot, trust your instincts that they cannot and don't appoint them co-guardians. You are just postponing the inevitable. However, as I've stated earlier, each case is different and I listen to each case on its own merits.

When the hearing is concluded, I generally give my decision from the bench. There are circumstances when a written decision is desirable (especially where there are significant law issues involved, *see, e.g.*, *In re Julia C.,* N.Y.L.J. 3/15/04, p. 20, col. 3). However, in most cases, I give a decision then and there. If there is no suitable family member or friend to appoint (a non-Part 36 appointment), I will appoint an independent guardian from the Part 36 list. Again, the court looks for people who want to serve. It is a very difficult job—more difficult than that of evaluator or counsel. There is no "28-day lifespan" to the role of guardian. A guardian's role may endure for years. Sometimes, there is money or a house; sometimes there is not. Sometimes, the court will require that the guardian's fee be paid from the net available monthly income and that the Department of Social Services adjust the budget accordingly. Other times, the work is pro bono.

Settling the Order and Judgment—within 30 days of the hearing (this allows the petitioner's attorney time to get a copy of the transcript of the decision and to prepare the Order and Judgment in accordance with the form from the Guardianship Clerk's office—note: before drafting any form, see if the clerk of the particular county has a form to be followed!), the Order and Judgment should be settled. Simultaneously, a copy of the proposed Order and Judgment should be e-mailed to my chambers. I can then incorporate changes into the final document without the necessity of the draft having to go back and forth from the Clerk's office.

I also require that a copy of the affirmation of legal services be served on all parties who have appeared. Of all the work I do, determining reasonable compensation is the second most difficult task. While it may not appear that way at times, I do remember what it is like to practice law and to maintain an office. I also know how much time should have been spent in any one case. Legal fees may be awarded in an Article 81 proceeding from the funds of an incapacitated person "only after the court first determines the reasonableness and necessity of the fees as well as the benefits inuring to the incapacitated person (Matter of Schwartz, 8/31/94, NYLJ, p. 25, col. 1)," *In re Muro*, N.Y.L.J., April 20, 1999, p. 30, col. 1 (Supreme Court Suffolk County). In determining the reasonable value of services rendered by an attorney, the court should consider "the nature of the litigation, the difficulty of the case, the time spent, the amount of money involved, the results achieved and amounts customarily charged for similar services in the same locality," *Smith v. Boscov's Dept. Store*, 192 A.D.2d 949, 596 N.Y.S.2d 575 (3rd Dep't 1993). *See also In re Freeman,* 34 N.Y.2d 1, 9 (1974). I will hold a hearing on the issue of fees in appropriate cases.

When the hearing is over and the Order and Judgment signed, this signifies only the beginning of a guardianship case. Approval of annual accounts, petitions to sell real property, gifting applications, and "so ordered" letters will follow—as will continue the needs of the incapacitated person. This court notes with great pride the excellent services rendered by the elder law bar in New York and the importance of the NYSBA Elder Law Section in keeping practitioners informed of current developments. Whether through the CLE programs, the Institutes or Section publications, it is hoped that the bench and bar will continue to learn about the concerns of each other—with the winners being those who can no longer help themselves, the persons subject to the Article 81 proceedings.

Joel Asarch is an Acting County Court Judge in Nassau County. He is the NYSBA Vice President from the Tenth Judicial District and in his spare time at night, teaches New York Practice at Touro Law Center and Legal Research at Nassau Community College. On the weekends, you can find him walking the boardwalk.

Legislative Op Ed

By John F. Cape, Director, New York State Budget Division

This year's state budget offers taxpayers an unprecedented opportunity. In his Executive Budget, Governor Pataki has proposed to solve, once and for all, the problem of runaway costs in the state's Medicaid program. It is the most comprehensive and sensible plan to deal with this problem that has ever been advanced, and we must enact it this year.

New York spends more on Medicaid than Texas, Pennsylvania and Florida *combined*. At a whopping $44 billion cost this year, the nation's most expensive Medicaid program is crushing the finances of governments at all levels—driving unacceptable local property tax increases, and robbing the state of resources that could be better used for education and economic development.

However, the Governor understands that the root cause of our Medicaid crisis lies in the outdated structure of our health care delivery system, and he proposes a series of fundamental reforms to correct those problems.

Thanks to evolving technology and advances in medicine, procedures that used to require long hospital stays can now be done on an outpatient basis. In addition, the focus on managed care has redirected services to community-based settings.

As a result, four out of every 10 hospital beds in New York State go unused. Yet we continue to pay for them.

As people age, these same medical advances are permitting more of us to choose the comfort of our own homes, for longer, instead of traditional nursing home settings.

As a result, thousands of nursing home beds are empty, yet we pay for them as well, while refusing to support the lower cost and higher quality of life offered by home care alternatives.

New York has one of the finest health care systems in world, but we simply cannot continue to finance a 20th century infrastructure to deliver 21st century health care. Moreover, to assure essential care is available to all who need it, we must make sensible judgments about the level of health benefits we can afford to provide.

To achieve that end, Governor Pataki has proposed a series of sweeping changes that would fundamentally reform the Medicaid system.

First, it protects local property taxpayers by capping the local Medicaid cost increases to only 3.5 percent in 2006, declining to a maximum rate of 3 percent by 2008, when the state will take over the Medicaid program—effective January 1, 2008.

While this unprecedented fiscal relief is a tremendous step forward, it will do little in the long term if it simply moves this crushing burden from one level of government to another. That's why the Governor has introduced a series of fair and sensible cost-containment measures that reduce the exploding costs of prescription drugs and bring the Family Health Plus program more in line with Healthy New York and other private health plans. Many of these proposals result from recommendations of the Governor's Health Care Reform Working Group—a collaboration of many of the state's finest and most experienced health care professionals.

Second, the budget calls for the creation of a bipartisan Commission on Health Care Facilities in the 21st Century to make recommendations on right-sizing the hospital and nursing home industries. To support this effort, the Governor is proposing the "HEAL NY" program that will provide $1 billion over the next four years to provide the resources to reconfigure hospitals and nursing homes, upgrade medical technology and provide critical support for community health centers.

Third, the Governor believes that nursing home care should be an option for everyone, but not the only option for anyone. Accordingly, he makes important changes and additional resources available to encourage home and community-based care options instead of more costly and less attractive institutionalized settings.

Lastly, by demonstrating our resolve and investment in restructuring the extraordinary costs of our Medicaid program, we position ourselves for enhanced assistance from the federal government to strengthen and improve health care for all New Yorkers.

2005 must be the year New York State reforms Medicaid, protects local property taxpayers and modernizes the State's Health Care system for the 21st century. The Governor's Executive Budget provides a sound blueprint to accomplish that important goal.

New York Case News

By Judith B. Raskin

Medicaid

HRA appealed from an order granting a community spouse a raised income allowance. Denied. *In re Bertha M. v. Pedro M. and Comm'r NYCHRA*, 4 Misc. 3d 1017(A), 2004 WL 1873645, Aug. 19, 2004 (Fam. Ct., Queens County).

Bertha M., a community spouse, sought an order of spousal support from her husband who was a nursing home resident and Medicaid recipient. The Support Magistrate found exceptional circumstances and financial distress and awarded Bertha M. an increase of $1,284 in her minimum monthly maintenance needs allowance (MMMNA). HRA appealed, arguing that there were no exceptional circumstances to justify the increase.

Bertha M. and her husband Pedro M. were both teachers in New York City. They had pensions and Social Security, but few assets. They did own an apartment with a mortgage.

The Support Magistrate found exceptional circumstances and upheld the support order. Bertha M. had very little in income-producing assets. She needed to pay the mortgage and other costs to maintain the apartment jointly purchased with her husband. She paid $300 per month for her own monthly medical expenses and she incurred costs of $100 per month for items for her husband such as clothing and Depends. She was responsible for paying a debt at the rate of $329 per month to settle federal and state income tax liabilities incurred by the couple jointly. She had significant costs associated with the purchase and maintenance of a car that made it possible for her to visit her husband daily, visits which the guardian *ad litem* determined were welcomed by her husband. Public transportation would have been too difficult for a woman of her age and cab rides would cost more than owning her car. Bertha M. filed for bankruptcy in 1997, which resulted in her inability to refinance her mortgage and car payments.

Thank you to Ronald Fatoullah, Esq. for bringing this case to my attention. Ron argued this case successfully for Bertha M.

Life Estate

Petitioner made application to determine how to value his life interest in property the court previously ordered sold. *In re the Estate of Strohe*, 2005 NY Slip OP 25103; 2005 N.Y. Misc. LEXIS 468, March 16, 2005 (App. Term, 1st Dept.).

The petitioner had previously obtained a court order directing the sale of real property in which he had been granted a life estate. Petitioner was now asking the court (1) whether he is entitled to his share of the proceeds as the life tenant outright or as an interest income from the entire proceeds and (2) if an outright interest, on what basis does he determine the value of his interest.

The court held that as the life tenant the petitioner is to receive his interest outright. A life tenant receives his share as an outright interest unless the court determines that an owner of some other interest in the property would suffer undue hardship as a result.

The court also held that the value of the life interest is determined pursuant to the method set forth in RPAPL § 403 and 406. This is a calculation by the Superintendent of Insurance taking into account the amount of the sale proceeds and the life tenant's age at the time of sale. The court concluded that this is the method to be used where, as in this case, no sufficient reason is given to use another method. The court rejected use of the IRS tables in IRC § 7520, stating that such tables are properly used for gift, estate and income tax valuation, but this not the preferred method to determine allocation of sales proceeds between life tenant and remainderman. The court also rejected respondent's suggestion that the court determine the valuation based on the facts of the case.

Trusts

Trustee sought to reform a testamentary trust requiring income distribution to the disabled beneficiary into a supplemental needs trust. Granted. *In re Proceeding for Reformation of Trust u/w/o Kamp*, 2005 NY Slip Op 25080; 2005 N.Y. Misc. LEXIS 363, February 22, 2005 (Surr. Ct., Broome County).

Mr. Kamp executed his will in 1977 when his mentally retarded son, Henry, was 22 years old. Mr. Kamp died in 1982.

For many years Henry's uncle, Frank Kamp, was trustee of a trust set up under Mr. Kamp's will for the benefit of Henry. The trust provided that Henry was to receive all of the income. Distribution of principal was discretionary. When Frank Kamp died in 2002, a bank was appointed as trustee and Henry was taking part in a Medicaid day treatment program.

The bank brought this proceeding to have the trust converted to a supplemental needs trust, so that it did not have to distribute the income to Henry. The income to Henry from the trust with principal of approximately $187,000, plus his Social Security Disability payments, made Henry ineligible for Medicaid payment for the program. The court granted the bank's request and permitted the reformation of the trust. Prior cases have split on the issue of permitting reformation where, as here, the testator died shortly after the *Escher* decision and before enactment of EPTL 7-1.12. This court-ordered reformation of the trust was based upon the strong public policy in favor of supplemental needs trusts, the presumed intention of the testator, and the Court of Appeals decision in *Shah* supporting Medicaid planning.

Health Care Proxy

Petitioner sought insertion of a PEG tube over objections of the health care agent and determination of the validity of the health care proxy. *Borenstein v. Simonson and West Lawrence Care Center*, 2005 N.Y. Slip Op. 50427U; 2005 N.Y. Misc. LEXIS 607, March 30, 2005 (Sup. Ct., Queens County).

This case was brought on an emergency basis and accepted by the judge as such. In this decision, the court describes the proper procedure for filing an emergency petition.

The case concerned a woman, Lee Kahan, who had been residing in a nursing home. She had previously signed a health care proxy appointing her daughter, Joan Simonson, as her agent. When she was admitted to a hospital suffering from advanced dementia, pneumonia, pulmonary edema, a urinary tract infection and other problems, the doctor inserted a nasogastric tube. This was intended as a temporary measure to provide needed hydration and nutrition. The doctors intended to then insert a PEG tube because the nasogastric tube could cause infection and aspiration. The health care agent rejected the PEG tube over the objection of other family members and doctors and Lee Kahan returned to the nursing home.

Three weeks later, Lee Kahan's sister, Rose Borenstein, brought this matter on an emergency basis to have the PEG tube inserted. She also asked the court to void the health care proxy or determine that the health care agent had no authority to make decisions regarding artificial nutrition and hydration. Rose Borenstein had previously been appointed as a co-guardian in an Article 81 proceeding where the issue was Lee Kahan's placement.

At the hearing, medical testimony supported the position that the nasogastric tube was not safe and that the PEG was the recommended procedure. The court reviewed Lee Kahan's health care proxy. In the space for optional instructions, Lee Kahan had inserted "If there is any hope of recovery, I want my agent to ask for life sustaining treatment." There were no other references to wishes about artificial nutrition or hydration. Witnesses testified that Lee Kahan was Jewish, held strong religious beliefs, and according to the tenets of the Jewish religion, she would opt for life. The health care agent testified that she did not think her mother had any quality of life, but did not want to do her any harm. Following the testimony, she agreed to the insertion of the PEG tube and the court then ordered that it be inserted.

The court then addressed whether to void the health care proxy or deny the agent the authority to make decisions regarding artificial nutrition and hydration. In reaching its decision, the court went into a detailed history of advance directives in New York, the provisions of the Health Care Proxy Law, various views on the subject of artificial nutrition and hydration and the beliefs of the Jewish religion in this regard.

The court did not void the health care proxy because it found that Joan did not act in bad faith. The court did say, however, that Joan did not follow the law which required her to act in her mother's best interests and take into account her mother's wishes and religious beliefs. The court held she cannot make decisions about artificial nutrition and hydration because her mother's wishes were not stated in the health care proxy and that in the future, all such available treatments should be provided to Lee Kahan.

The court concluded with a reference to the Schiavo case and a message that ideally families would resolve these issues without the need for court involvement.

Judith B. Raskin is a member of the law firm of Raskin & Makofsky, a firm devoted to providing competent and caring legal services in the areas of elder law, trusts and estates, and estate administration. Judy Raskin maintains membership in the National Academy of Elder Law Attorneys, Inc.; the NYSBA, where she is a member of the Elder Law and Trusts and Estates Law Sections; and the Nassau County Bar Association, where she is a member of the Elder Law, Social Services and Health Advocacy Committee, the Surrogate's Trusts and Estates Committee and the Tax Committee. Ms. Raskin has appeared on radio and television and served as a workshop leader and lecturer for the Elder Law Section of the NYSBA as well as for numerous other professional and community groups. She is a member of the Legal Committee of the Alzheimer's Association, Long Island Chapter, and is past president of Gerontology Professionals of Long Island, Nassau Chapter.

Legislative News

By Howard S. Krooks and Steven H. Stern

Howard S. Krooks

For the past several months, elder law attorneys have been focused on the proposed changes to the Medicaid eligibility rules. However, New York State lawmakers have numerous proposals currently under consideration that affect seniors and their families. Here are a few:

The Caregiver's Assistance Act

Assemblyman Steve Englebright (D-Setauket) has introduced legislation which would establish the "Caregiver's Assistance Act." Bill A.05276 (S. 1194) would allow a personal income tax credit equal to 20 percent of qualified care expenses in an amount equal to or less than $2,400 for the taxable year that are paid by the taxpayer for the care of a qualifying senior family member. In addition, the proposal authorizes a basic or an enhanced (STAR) exemption on a prorated basis to property where a senior citizen residing with a taxpayer would otherwise meet the eligibility requirements, except for ownership requirements, and where, in the case of an enhanced exemption, the income of the senior and the spouse of the senior considered separately from the remainder of the household would meet the applicable income requirements.

Capping Medicaid Costs to the Counties

Escalating Medicaid costs continue to place a great burden on the counties in New York State, causing most to raise taxes and cut services. Many state lawmakers believe that the state should accept responsibility for any Medicaid costs above the current level. Proposed legislation (S. 294/A. 00320) would provide for the state to reimburse the local social services district for the difference between the Medicaid costs of the district in each fiscal year and the Medicaid costs met by such district at the close of the fiscal year immediately prior to the enactment of this legislation. According to the legislative summary, the state should accept responsibility for any Medicaid costs above the current level. And although the fiscal implications are unclear, the hope is that the state will now be forced to act in a responsible manner with respect to escalating Medicaid costs.

Steven H. Stern

The New York State Housing Opportunities Partnership Act

The development of senior housing continues to be a major issue throughout New York State. A bill has been introduced (S. 02972/A. 2301) to create a new governmental agency to expand senior housing opportunities. This new entity would be known as the New York State Senior Housing Opportunities Partnership Authority. According to the bill summary, such authority would finance or collaborate in the financing of senior housing opportunities facility projects across New York.

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

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

Practice News

An Overview of Social Security Retirement Benefits for the Elder Law Attorney

By Vincent J. Russo and Marvin Rachlin

This article provides the practitioner with an overview of Social Security retirement benefits. Some clients are unaware of entitlements that are outlined herein. With this information, the practitioner will be able to respond to these issues and ensure that clients receive all of the benefits they are entitled to.

Marvin Rachlin (l) and Vincent J. Russo

When the Social Security system was first enacted into law in 1935,[1] it was the first federally sponsored pension system. At that time, employment-related and private pensions were virtually non-existent. Social Security quickly grew to become the primary post-retirement income source for millions of Americans. In spite of the many changes since 1935, and the growth of employment-based pensions and personally funded pensions, Social Security old age benefits remain the primary income source for millions of senior citizens.

Retirement Age Requirements. For the first 65 years of Social Security, the age of 65 remained the retirement age necessary to receive full benefits from Social Security. It is probably coincidental that when the Social Security system reached the retirement age of 65, it changed the rules to increase the age of retirement necessary to receive full benefits.

As of the year 2000, the age of retirement will rise in stages reaching age 67 by the year 2022.[2] Each incremental increase will therefore be very small, one month for each year.

It also remains possible for an individual to retire and receive reduced Social Security benefits as early as age 62.[3]

Once an individual elects to receive early retirement benefits, the reduced rate will remain applicable for the rest of the individual's retired life. The amount of the reduction will be based upon the age of early retirement which can be anywhere between 62 and 65. The reduced level of benefits will be based on the age of retirement.

Earnings Requirements for Benefits; Necessary Quarters. An individual must be fully insured in order to be eligible for retirement benefits based on age. To be fully insured, an individual must have a minimum of 40 quarters of reported earned income, provided such individual was born after 1928.

For persons born prior to 1928 and earlier, the number of required quarters is lower, reducing down to as low as 33 quarters for individuals born in 1922.

Earning Requirement for Each Quarter. Until 1977, earnings of $50.00 were sufficient for a quarter's credit. Since 1977 the amount of earnings required to achieve full credit for a quarter has been raised incrementally to the current rate of $900.00 for the year 2004.[4] All earnings are credited annually. Thus, based on a quarterly earnings requirement of $900.00, if an individual worked only one quarter, but earned $3,600.00 or more, such person would have credit for four quarters or one year. Earnings in excess of the annual amount do not increase the individual's benefit level.

Being fully insured is not only a requirement for the individual to receive old age benefits from Social Security, but it is also a requirement for the availability of benefits to dependents or survivors.

Retirement after Age 65. If an individual continues to work after age 65 and does not apply for Social Security retirement benefits, the credited earnings will raise the individual's entitlements above the age 65 maximum, and will continue to do so until age 70.[5]

Earnings beyond age 70 will not increase the individual's entitlements, even if said individual does not apply for Social Security retirement benefits until after age 70.

Earnings Limitations for Individuals Receiving Social Security Retirement Benefits Prior to Year 2000. Prior to the year 2000, it was possible for a

Social Security old age recipient to earn a certain amount of earned income without reducing benefits.[6] Prior to the year 2000, a retiree, 65 years or older, could earn up to $15,500.00 a year without affecting receipt of benefits. For an individual aged between 62 and 65, the amount is $10,080.00.

For those 65 years of age or older, earnings above $15,500.00 would have reduced Social Security benefits by $1.00 for each $3.00 of earnings above the maximum. For those aged between 62 and 65, earnings above $10,800.00 reduced Social Security benefits by $1.00 for each $2.00 of earnings in excess of the maximum.

Repeal of Earnings Limitations for Individuals over the Age of 65 for Social Security Retirement Benefits. Effective January 1, 2000, all earnings limitations for individuals over the age of 65 were eliminated.[7] Prior to the change in law, earnings limitations were waived only for persons over the age of 70. The new law extended this benefit for all those 65 or older. For early retirees between the ages of 62 and 65, the earnings limitations referred to above continue to apply. For those individuals over the age of 65 who receive Social Security retirement benefits and continue to work, their earnings will not increase their entitlements between the ages of 65 and 70 as it would if they were not collecting benefits. Thus, a fully employed individual who is over the age of 65 can continue to work and receive full Social Security benefits without regard to income.

Unearned Income. Social Security has never considered unearned income when determining eligibility or benefit amounts for old age benefits. Income such as interest or dividends (other than wages) has never been counted. Such unearned income will not reduce the benefits of individuals between the ages of 62 and 65 in receipt of Social Security old age benefits.

Eligibility for Someone Other than the Wage Earner. When an individual is receiving Social Security benefits in any category, his or her qualified dependents may also receive benefits based on a percentage of the wage earner amount.

> ***Spouse of Wage Earner.*** The spouse of an old age benefits recipient is entitled to 50% of such individual's benefit provided the spouse is 65 years or older.[8] If the spouse is between 62 and 65 the entitlement is 37½% of the benefit. If the spouse is under 62, no benefit is available.
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> ***Parent of Wage Earner.*** A parent of a wage earner receiving benefits is eligible only if the spouse of the wage earner is too young (under 62) and there is a dependent child under the age of 16, or if older than 16, is disabled and receiving a benefit on the wage earner's account. Another condition of eligibility is that the parent's earnings cannot exceed the earnings limit of a person under the retirement age which is $11,640.00 for the year 2004. The parent must either live with the dependent child or exert some degree of parental control over such child. A parent of a retiree is entitled to a benefit equal to 82½% of the retiree's benefit. If both parents are alive, then each will be entitled to 75% of the retiree's benefit.
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> ***Parent of Deceased Wage Earner.*** If the surviving spouse or surviving divorced spouse is under the age of 60 and ineligible for widow or widower benefits, the parent or parents of the deceased wage earner may be eligible subject to the same conditions set forth in the paragraph immediately above. The benefit levels are the same as they would be if the wage earner were alive.
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> ***Divorced Spouse.*** A spouse who was validly married to the wage earner for at least 10 years prior to the final divorce decree, and who has been divorced for at least two years, and is 62 years old or older or disabled, is eligible for benefits based on the earnings record of the divorced wage earner.
>
> If the divorced spouse meets all of the requirements, he or she can receive benefits even if the wage earner, who must be fully insured, does not apply and is not receiving benefits.[9] The benefit level for a divorced spouse aged 65 or older is 50% of the wage earner's calculated benefit; and 37½% if the divorced spouse is between 62 and 65. Although a valid marriage is a prerequisite for divorced spouse benefits, it is possible for a marriage to be deemed valid if the divorced spouse was completely innocent. That is, he or she entered into the marriage in good faith, with no knowledge of any legal impediment prior to entering into the marriage or during the existence of the marriage.[10]
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> ***Child of Wage Earner.*** An unmarried, dependent child of an old age, retirement, disabled, or deceased beneficiary who is under the age of 18, or under the age of 19, if a full time student, is entitled to benefits equal to 50% of the wage earner's benefit level.

This benefit applies to adopted children and to children born out of wedlock, if paternity was established by court order or by a written acknowledgment.[11] A child over the age of 18 who is disabled, providing the disability began before age 22 is also eligible for benefits based on the account of a parent receiving benefits. The disabled child's benefits will continue as long as the child remains disabled and unmarried. The benefits will continue even if the disabled child marries, provided the marriage is to an individual who also receives disability benefits.

Surviving Child of Deceased Wage Earner. All of the requirements and standards for dependent children of living wage earners apply as set forth in the paragraph immediately above. The only difference is that the benefit level for a surviving child will be 75% of the deceased wage earner's entitlement, whereas the benefit level of a child of a living recipient of old age benefits is 50%.

Stepchild. A stepchild is the child of a parent whom the wage earner marries. The wage earner must have provided at least half of the stepchild's support, and they must have lived together for at least one year before the application for benefits by the wage earner. If the stepparent is deceased, the child must have been the wage earner's stepchild for at least nine months immediately preceding the day on which the stepparent died, unless the death was accidental. The benefit level would be 50% of the stepparent's benefit.

Surviving Stepchild of Deceased Wage Earner. The criteria for a surviving stepchild's eligibility from a deceased wage earner are the same as those set forth in the paragraph immediately above. The stepchild would receive 75% of the deceased wage earner's benefit level.

Grandchild. A grandchild is entitled to benefits from the account of a recipient grandparent wage earner, but only if the grandchild's own parents are both deceased or disabled. In such cases the grandparent must have provided at least half of the support for the grandchild for one year or longer prior to the grandparents filing for benefits. If the grandparent was disabled until benefits were applied for, then the dependency support requirement is replaced by a requirement that the grandchild must have lived with the grandparent for one year prior to filing for benefits.[12] The benefit level for a grandchild is 50% of the grandparent's benefit level.

Surviving Grandchild of Deceased Wage Earner. Surviving grandchildren are eligible only if they meet the eligibility criteria set forth in the paragraph immediately above. The benefit level is 50% of the deceased wage earner's benefit level.

Survivors Benefits/Surviving Spouse of Deceased Wage Earner. Benefits to a surviving spouse of a deceased wage earner are often referred to as Widow's or Widower's Benefits. As with the spouse of a living wage earner, there must be a valid marriage.

The parties must have been married for at least nine months prior to the death of the wage earner. This requirement is waived if the wage earner's death was accidental or unexpected. The nine month requirement is also waived if the deceased wage earner and surviving spouse were the parents of a child under the age of 18.[13]

If the surviving spouse is over the age of 65, the benefit level will be 100% of the deceased spouse's benefit level. If the age of the surviving spouse is between 62 and 65, the benefit level will be 82½% of the deceased wage earner's level, and if between the ages of 60 and 62 the percentage is reduced to 71½%. Below age 60 the surviving spouse of a deceased wage earner is not entitled to any benefits from the account of the deceased wage earner, unless the surviving spouse is disabled, in which event he and/or she will be entitled to 71½% of the deceased wage earner's benefit level.

Divorced Surviving Spouse. The surviving divorced spouse of a deceased wage earner will be eligible for benefits from the deceased wage earner's account provided the parties had been married for at least ten years prior to the entry of the final divorce decree, and the surviving divorced spouse is 60 years old or older; and unmarried. The benefit level for a surviving divorced spouse will be 50 percent of the deceased wage earner's benefit level, for all ages over 60.

Alien Eligibility. Citizenship has never been an eligibility requirement for Social Security benefits until 1997. Alien eligibility was narrowed by the Personal Responsibility and Work Opportunity Reconcil-

iation Act of 1996.[14] That law which drastically affected Medicaid and SSI eligibility, also affected eligibility for Social Security benefits.

As of August 1997, an alien must be a lawful resident of the United States and must be "qualified." The requirements to be a qualified alien are the same as they are for Medicaid and SSI. The criteria are the same as they are for Medicaid and SSI.

For a more complete understanding of Social Security benefits, we refer you to *New York Elder Law Practice*, Russo & Rachlin. West Group (1-800-328-4880).

Endnotes

1. 49 Stat. 623, 1935.
2. 42 U.S.C. § 416.1.
3. 20 C.F.R. § 404.310.
4. 20 C.F.R. § 404.140.
5. 20 C.F.R. § 404.313.
6. 20 C.F.R. §§ 404.416 *et seq*. and 404.434 *et seq*.
7. Senior Citizens' Freedom to Work Act of 2000, 114 Stat. 198, P.L. 106-182.
8. 20 C.F.R. § 404.333.
9. 42 U.S.C. § 402(b) and (c).
10. 20 C.F.R. § 404.346.
11. 20 C.F.R. § 404.355.
12. 20 C.F.R. §§ 404.358, 404.368.
13. 20 C.F.R. §§ 404.335 *et seq*.
14. P.L. 104-193, § 401(b), (2).

Vincent J. Russo is the Managing Partner of the Elder Law and Estate Planning Firm of Vincent J. Russo & Associates, P.C., of Westbury, Islandia, Woodbury, Smithtown and Lido Beach, New York.

Marvin Rachlin is Of Counsel to the law firm of Vincent J. Russo & Associates, P.C., and former Counsel to the Department of Social Services, Nassau County.

The Fair Hearing News

By Ellice Fatoullah and René H. Reixach

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

In re the Appeal of J. B.

Ellice Fatoullah

Holding

An increase in the Community Spouse Resource Allowance ("CSRA") to generate additional income for the community spouse should be remanded to the local Agency to determine how much of the Appellant's excess resources are necessary to purchase a single premium immediate life annuity to generate the required income.

Facts

On February 27, 2004, an application for Medical Assistance ("Medicaid") was filed on behalf of the appellant, age 88. The Appellant had been residing in a Residential Health Care Facility since November 24, 2003. The Appellant died on June 7, 2004; his widow, age 84, resides in the community.

By notice dated May 12, 2004, the Medicaid application was denied for excess resources, and on June 16, 2004, the Appellant requested this fair hearing. A "revised" notice was issued October 1, 2004, again denying the application due to excess resources.

In both notices, the Agency calculated that the Appellant and his community spouse had $277,341.99 of countable resources, of which $257,522.57 was owned by the community spouse. The Agency computed that the maximum CSRA was $92,760.00, and after deducting the $3,850 Medicaid resource level for one person in effect in 2003, the Agency determined that the Appellant had $180,731.99 of excess resources.

In the October 1, 2004 revised determination, the Agency determined that the Appellant had $771.50 of net available monthly income, after disregarding the $50.00 monthly personal needs allowance and $123.50 for a health insurance premium, and that the community spouse had monthly income of $1,307.04. Since the Minimum Monthly Maintenance Needs Allowance ("MMMNA") for 2003 was $2,267, the community spouse's income was $959.96 less than the MMMNA. Even after allocating all the Appellant's $771.50 of net available monthly income to the community spouse, she still had monthly income that fell $188.46 per month below the MMMNA.

René H. Reixach

Applicable Law

To determine eligibility, an applicant's net income must be calculated, and resources must be compared to the applicable resource level. Net income is derived from gross income by deducting exempt income and allowable deductions. The resulting net income is compared to the statutory standard of need set forth in Social Services Law § 366.2(a)(7) and 18 N.Y.C.R.R. Subpart 360-4. If an applicant's net income is less than or equal to the applicable monthly standard of need, and resources are less than or equal to the applicable standard, full Medicaid coverage is available.

If the applicant's resources exceed the resource standards, the applicant will be ineligible for Medicaid until he/she incurs medical expenses equal to or greater than the excess resource standards, pursuant to 18 N.Y.C.R.R. § 360-4.1. Section 360-2.4(c) of the Regulations provides that an initial authorization for Medicaid will be made effective back to the first day of the first month for which eligibility is established. A retroactive authorization may be issued for medical expenses incurred during the three months preceding the month of application for Medicaid if the applicant was eligible for Medicaid in the month such care or services were received.

Section 360-4.10 of the Regulations provides for the treatment of income and resources when a married Medicaid applicant requires institutional health care and his or her spouse continues to reside in their community. Section 360-3.10(c)(7) of the Regulations provides that if either spouse establishes that the

income generated by the CSRA, established by the social services district, is inadequate to raise the community spouse's income to the MMMNA, the department must establish a resource allowance adequate to provide the MMMNA from those resources considered to be available to the institutionalized spouse.

Discussion

The Agency Representative testified that the Agency issued a "revised" denial notice because in its original budgetary calculations the Agency had incorrectly used the $92,760 CSRA for 2004. The Agency Representative stated that the Agency should have used the $90,660 CSRA for 2003, but she acknowledged that in its revised notice the Agency determined to stay with the original excess resource amount of $180,731.99.

The Agency representative further contended that in its original calculations the Agency failed to include $746.04 in monthly interest income received by the community spouse. She explained that after this interest income was credited to the community spouse, her monthly income allowance from the Appellant's income was reduced to $959.96. She acknowledged that after allowable deductions, only $771.50 of income was available from the Appellant, which left the community spouse with monthly income that was $188.46 below the MMMNA.

The Appellant's attorney did not dispute any of the Agency's calculations regarding the income and resources of the Appellant and his community spouse. He contended that 18 N.Y.C.R.R. § 360-4.10(c)(7) and Social Services Law § 366-c(8)(c) require that the resource allowance of the community spouse be increased to include all the combined resources of the Appellant and his spouse since they are necessary to generate sufficient income to allow the spouse to meet the MMMNA of $2,267. The Appellant's attorney pointed out that the total combined monthly income, including interest income from the so-called "excess resources" was $188.46 below the MMMNA. He maintained that the so-called excess resources must therefore be made available to the Appellant's community spouse in order to enable her to receive the MMMNA provided by law.

The Agency attorney did not dispute that the community spouse's income needs to be raised to the MMMNA. He contended, however, that it would be excessive to award the Appellant's community spouse all of the excess resources of $180,731.99. He pointed out that only about seven months of income are at issue and maintained that it is unreasonable to provide the community spouse with $180,731.99 in resources to make up about $1,300 in income. He requested that the Commissioner remand this matter to the Agency, so that the Agency can determine how much of the excess resources are needed to generate income to bring the community spouse up to the MMMNA for the "finite" time period at issue. He contended that the Agency's position is supported in a previous Decision after Fair Hearing which he submitted into the record.

The previous Decision, Fair Hearing number 4042926P, can be summarized as follows: a nursing home resident applied for Medicaid on August 13, 2003. The Agency denied his application on December 29, 2003 due to excess resources, and the applicant died on January 6, 2004. The Applicant had a community spouse who sought an award permitting her to retain all excess resources ($89,097.28) to generate income to bring her closer to the MMMNA. After the Fair Hearing, the Commissioner's Designee found that since the monthly income available to the community spouse was $26.36 below the MMMNA, the spouse was entitled to retain those resources necessary to generate income to bring her income closer to the MMMNA. The Commissioner's Designee recited in her discussion that "[t]he Agency should determine how much of the resources will be necessary to bring the [community spouse] to the MMMNA level ($27.00 a month), and advise [her] of such determination." The matter was then remanded to the Agency to redetermine the Applicant's eligibility for Medicaid based upon the discussion. In the decretal, the Agency was directed to "increase the [CSRA], thereby allowing her to retain only those resources that will generate the additional income needed to bring Appellant to the MMMNA."

The Agency's determination in the present case was correct when made. The uncontroverted evidence in this case establishes that the income generated from the CSRA is inadequate to raise her income to the MMMNA. Consequently, the Appellant's spouse has established that she is entitled to retain a CSRA in excess of the maximum resource allowance.

The Agency's argument that this matter should be remanded so that the Agency can determine how much of the excess resources are necessary to bring the community spouse up to the MMMNA for the "finite" period of about seven months is found to be unpersuasive. At the time of the initial Agency determination on May 13, 2004, the Appellant was still alive and residing in a skilled nursing facility. The circumstances of this case must be reviewed as they existed on May 13, 2004 and the benefit of hindsight regarding the Appellant's demise on June 7, 2004 cannot be used. In addition, the previous Decision after Fair Hearing has been reviewed and it is found that

this decision does not support the Agency's argument that only a finite period needs to be dealt with in this proceeding.

However, 18 N.Y.C.R.R. § 360-4.10(c)(7) provides that the resource allowance established by the department must be adequate to provide the MMMNA from those resources considered to be available to the institutionalized spouse. Therefore, this matter will be remanded to the Agency so that it can determine how much of the excess resources are needed to purchase a single premium immediate life annuity to generate sufficient monthly income to raise the community spouse's total available income up to the MMMNA, taking into account the circumstances of the Appellant and his spouse as they existed on May 13, 2004. The excess resources are intended for the purpose of purchasing an annuity contract to provide the additional income needed to raise the community spouse to the MMMNA after having added together the community spouse's income, any contribution from the Appellant, and the interest income generated by the $92,760 resource allowance.

Fair Hearing Decision

The Agency's determination to deny the Appellant's application for Medicaid on the grounds that the Appellant had excess resources was correct when made. The Agency is directed to determine how much of the Appellant's excess resources are necessary to purchase a single premium immediate life annuity to generate sufficient monthly income to raise the community spouse's total available income up to the MMMNA, taking into account the circumstances of the Appellant and his spouse as they existed on May 13, 2004. After making that determination, the Agency is directed to increase the CSRA and allow the Appellant's community spouse to retain only those excess resources that are necessary to generate the additional income to bring the community spouse up to the MMMNA.

The Agency is directed to re-determine the Appellant's eligibility for Medicaid, and if the Appellant is found to be eligible, to provide Medicaid retroactive to the month of application and three months prior thereto, if otherwise eligible. The Agency is directed to provide the Appellant with a reasonable opportunity to submit verification of unpaid medical bills for the period from on or about November 1, 2003 to June 7, 2004 to offset excess resources.

Editor's Comment

This is the first of several recent Decisions after Fair Hearing, including Decisions from Delaware and Nassau Counties, applying what appears to be a new state policy that increases in the CSRA must be determined by the local Agency on remand based on how large a single premium immediate life annuity would be needed to generate the income to bring the community spouse's income up to the MMMNA. This approach raises several legal and practical issues.

The remand to the local Agency to determine the amount of resources to be protected violates the requirement of Social Services Law § 366-c(8)(c) that such an increase must be determined by "the department." Social Services Law § 2.1 defines "the department" as meaning, for the Medicaid program, the New York State Department of Health, not the local social services district. This Decision violates the statutory requirement that the increase be determined by "the department" by remanding to the local Agency.

This new policy, if it otherwise were valid, should have been promulgated as a regulation after notice and comment rulemaking, since it is a policy of general applicability affecting the public. The failure to do so makes it invalid under State Administrative Procedure Act §§ 202 and 203, Executive Law § 102 and Article 4, § 8, of the State Constitution.

Substantively, the new policy ignores the difference between income and resources. Part of what is received back after purchase of an immediate annuity is a return of principal. For example, if an annuity is purchased for $100,000 and it pays $1,000 per month to someone with a 10-year life expectancy, 5/6 of those payments is a return of principal. Only 1/6, or about $166.67 per month, is income. This contravenes the federal spousal impoverishment statutory provision that the CSRA should be increased if, "in relation to the amount of income generated by such an allowance," it is inadequate to raise the community spouse's income to the MMMNA. See 42 U.S.C. § 1396r-5(e)(2)(C). This Decision after Fair Hearing lumps the increased CSRA and income together and treats them both as income because of the way annuities are paid out.

Finally, this Decision ignores the concept that resources are determined as of the "snapshot" date, i.e., as of the beginning of the first continuous period of institutionalization, in this case November, 2003. See 42 U.S.C. §§ 1396r-5(c)(1)(A)(ii) and 1396r-5(f)(2); Social Services Law §§ 366-c(2)(c) and (d). The Decision incorrectly directs that the CSRA be determined as of May 2004, six months after the date on which the CSRA is to be determined.

The approach of having each local social services district determine what annuity policy to use in making these determinations also raises a possible viola-

tion of the requirement of federal law that the state plan for Medicaid must "be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them." 42 U.S.C. § 1396a(a)(1). Federal law also requires that eligibility based on resources must be determined using a "single standard." 42 U.S.C. § 1396a(a)(10)(C)(i)(I). Instead of there being a single standard for evaluating resources in cases like this, mandatory on each local district, there will be separate standards for each district.

The Appellant at this Fair Hearing was represented by ***Stephen K. Koldin****, of East Syracuse, New York.*

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

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

Request for Articles

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

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

Public Elder Law Attorney News

New Requirement to Prove "Disability" When Using NYSARC Pooled Trust to Reduce or Eliminate the Medicaid Spend-down

By Valerie J. Bogart

On February 25, 2004, the fair hearing decision in the case of *Mary O* established the right of Medicaid recipients with disabilities to deposit their excess income into a Supplemental Needs Trust to reduce or eliminate their spend-down.[1] *Mary O* involved deposits into the NYSARC pooled Supplemental Needs Trust ("SNT"), also called "D-4-C" trusts based on 42 U.S.C. § 1396p(d)(4)(C). Pooled trusts, unlike individually drafted SNTs—which are also called "D-4-A" trusts based on 42 U.S.C. § 1396p(d)(4)(A)—are available to people age 65 or over as well as to people under age 65. For either type of trust, the beneficiary must be "disabled," regardless of her age. The policy and procedures for how Medicaid will determine disability for people age 65 or over have evolved since the *Mary O* decision was issued. For this age group, no determination of "disability" is usually on file, since neither the Social Security Administration or the Medicaid agencies have any reason to make such a determination for purposes of eligibility. Therefore, a new procedure has been established by the New York State Department of Health. Unfortunately, the burden of these procedures poses yet another barrier to use of the SNT to reduce or eliminate spend-down.

It is worth negotiating procedures, because use of the SNT to eliminate spend-down has at least three other benefits. One benefit is that by reducing one's countable income, the client can qualify for one of the Medicare Savings Programs—QMB, SLIMB, or QI-1, for people whose income is up to 135% of the Federal Poverty Line.[2] In each of these programs, Medicaid pays the client's Medicare Part B premium which in 2005 is $78.20—in effect, offsetting the NYSARC monthly fees. In QMB and SLIMB, Medicaid also pays some of the other out-of-pocket Medicare costs. Second, a corollary benefit of joining a Medicare Savings Program (MSP) is that MSP enrollees will be automatically enrolled in the Low Income Subsidy for the Medicare Drug plan which begins January 1, 2006.[3] This Subsidy is crucial to pay the high premiums, copayments, and significant gaps in the Medicare drug plan. Third, while people with an income spend-down are generally excluded from Medicaid Managed Care, in a recent fair hearing, State DOH reversed Nassau County's attempt to disenroll a Medicaid recipient from Medicaid Managed Care because she had a spend-down, which she deposited into a Supplemental Needs Trust.[4] The decision held that if income is deposited into an SNT, there is no spend-down, so the client continued to be eligible for Medicaid Managed Care.

First, the Social Security Act defines a pooled SNT as "[a] trust containing the assets of an individual who is disabled (as defined in section 1614(a)(3)) [42 U.S.C.S. § 1382c(a)(3)] that meets the following conditions . . . " 42 U.S.C. § 1396p(d)(4)(C). An individual trust is defined the same way, with the limitation that the individual also be under age 65. 42 U.S.C. § 1396p(d)(4)(A). Significantly, this definition does not require that the individual has been *determined* as disabled. Instead, the trust is for an individual who *is* disabled. The significance of this definition affects the retroactive effect of enrolling in the NYSARC or other pooled or individual trust. The client need not first be determined "disabled" in order to enroll in the NYSARC trust. S/he may enroll, and then request a determination from the Medicaid program at the same time that s/he submits the completed SNT enrollment documents for approval. Of course, the client should be advised of the risk that if Medicaid does not agree that the client is disabled, and if that finding is sustained on appeal after a fair hearing, then enrollment in the SNT accomplishes nothing and will have no effect on spend-down, retroactively or prospectively. If the client is found disabled, however, assuming that her condition was the same when she enrolled in the SNT, then she was eligible when she enrolled and her spend-down should be adjusted retroactively.

- CAUTION: Attorney should be knowledgeable enough about Social Security standards for determining disability to evaluate and advise client on risk of adverse determination, and to assist client in documenting disability.

On February 2, 2005, the NYS Department of Health (DOH) issued a letter to the New York City Human Resources Administration to clarify the pro-

cedures for determining disability.[5] The letter states that:

1. Persons over 65 *can* be considered disabled; and
2. Determinations of disability are going to be made utilizing the standards set for Social Security Disability or SSI, including Ruling 03-3p, "Evaluation of Disability and Blindness in Initial Claims of Disability for Individuals Aged 65 or Over."[6]

The DOH letter stated that the M11q (physician's order for personal care/home attendant care used in New York City) is NOT sufficient to establish disability. Instead, clients must submit the following two forms and other pertinent medical evidence to their local Medicaid office processing their case, which in turn must forward the forms to the State Disability Review team in Albany to determine disability. The forms are:

- Forms 486T—filled out by treating physician. The posted document is 25 pages long. However, the basic form is only the first two pages. The rest of the pages are attachments for different impairments. The doctor(s) should fill out only those attachments that pertain to the client's impairments. Form posted at http://www.wnylc.net/pb/docs/DSS_486-New.pdf.
- Form 1151—Completed by the client or her family or advocate. This form records the client's educational and work background, and sources of medical treatment. Posted at http://www.wnylc.net/pb/docs/DSS_1151-New.pdf.

Proving disability can be a complicated process, but is made easier for those age 65 or over. A sequential evaluation process is used. This process is briefly described in the above-referenced Social Security Ruling 03-3p, which also gives some shortcuts to the usual evaluation process for the elderly.

- Listed Impairments—Social Security publishes "the listing" of impairments, which are criteria for finding that a particular impairment is so severe that the person is found disabled without looking further at age, education, or work experience. Consider whether the client has any impairments that may meet the requirements of the listings—there is one for each body system.[7] Show the relevant listings to the doctor, and ask the doctor to verify whether she meets any of them. The doctor may not just give her opinion, but must document that the specific criteria for lab findings, signs and symptoms are met.
- Use of Evidence Other than DSS-486 and 1151—Alzheimer's disease and other impairments. While the February 2005 DOH letter expressly states that the M11q is not a substitute for forms 1151 and 486T, DOH does state that the approved forms "and all pertinent medical evidence" should be forwarded by HRA (or other local district) to the Disability Review Team in Albany. The listing for Alzheimer's disease is an example of how other documentation should be submitted. The listing for this impairment is Section 12.02 *Organic mental disorders.* Note that this listing includes many functional impairments, such as "Marked restriction of activities of daily living," or "Marked difficulties in maintaining social functioning."
  - TIP: For clients who have already been evaluated for eligibility for personal care services, the assessment forms used by the local districts, as mandated by state regulations at 18 N.Y.C.R.R. § 505.14(b), may provide extensive evidence that the client meets these functional requirements. In the first case handled by Selfhelp using the new procedures, we requested in our cover letter submitting the 486 and 1151 that HRA (CASA) submit to the State Disability Review team in Albany the entire battery of assessments done when our client's home care was authorized—the social assessment, nursing assessment, local medical director review, etc. These evaluations were replete with findings relevant to the listing for Organic Mental Disorders. If a fair hearing is later necessary, the failure to consider these documents will be raised.
- Under Social Security Ruling 03-3p, an impairment is assumed to be "severe" for persons age 72 or over. This does not mean DISABILITY is assumed, but that one only has to prove the fact that there is a medically determinable impairment to proceed to the next step of the sequential evaluation process, which is whether the individual can return to past relevant work or can perform any other work, considering her age, education, and work experience.
  - If the client has no "past relevant work," meaning she did not perform substantial

gainful activity in the last 15 years,[8] or can no longer perform "past relevant work," the Ruling 03-3p uses two special vocational profiles. If client has a "severe impairment" (see note above, stating that for people age 72 and over, an impairment is *deemed* to be severe) and meets either of these profiles, "a finding of disabled must be made." Ruling, p. 5.

  - The "past arduous work" profile—
    * Individual did 35 years of arduous physical unskilled labor which s/he can no longer do because of impairments, and
    * has a marginal education (6th grade or less).
  - The "no work experience" profile—
    * Has not worked in 15 years,
    * Is age 55 or over,
    * Has a limited education (11th grade or less).

- If either of the special profiles above do not apply, then the regular vocational-educational rules apply in Appendix 2 of subpart P of 20 CFR Part 404. Since that chart ends at age 64, the Ruling directs use of the rules for people age 60-64 for people age 65+. The Ruling, p. 5 describes how these rules apply to people age 65+. You will see that only the most highly educated clients or those with skilled work experience in the last 15 years will not be found disabled. Lack of English literacy is considered and helps establish disability.
- A model cover letter to the local Medicaid office, enclosing the completed 486 and 1151, is posted that will help take you through these steps. You can edit it, deleting the parts that don't apply. See http://www.wnylc.net/pb/docs/SAMPLECOVERLETTERTOMEDICAIDWITHTRUST.pdf.

FOR OTHER INFORMATION—Most of the information in this article is in a training outline posted at http://www.wnylc.net/pb/docs/SNTOutline.pdf. The NYSARC trust documents and other materials on SNTs are posted at http://www.wnylc.net/pb/docs/SNT_Materials.htm. Please check there periodically for updates to the outline and other materials.

Endnotes

1. Fair Hearing Decision No. 3945750N, *In re Mary O*, dated Feb. 25, 2004 (Aytan Bellin, Atty. for Petitioner) (available at wnylc.net in Online Resource Center).
2. 42 U.S.C. § 1396d(p); 1396a(a)(10)(E)(iii-iv); 42 C.F.R. § 406.1 *et seq.*; *see* http://www.health.state.ny.us/nysdoh/mancare/omm/savingsprogram/medicaresavingsprogram.htm.
3. Medicare Modernization Act § 101, creating § 1860D-23.
4. Fair Hearing Decision No. 4080991J, dated 05-17-2004.
5. A copy of the letter is available at http://www.wnylc.net/pb/docs/Lette_%20from_DOH_on_Disability_Determinations_and_Pooled_Trusts.pdf.
6. Posted at http://www.wnylc.net/pb/docs/Social%20Security%20Ruling%2003-3p.pdf.
7. The listing is in federal regulations at 20 CFR. Part 404 Subpart P Appendix 1. It is online at http://www.government-guide.com/main.adp. Click on "Benefits and Assistance" in menu on left. Click on Social Security in middle menu. Then click on "Social Security Main" under Social Security and Medicare Basics at top of screen. In middle of next screen, under "Disability and SSI," click on "More disability information." This screen has lots of information. For the listings, click on right under "More Information" on "For Health Professionals—Disability Evaluation Book Now Online." Scroll down to the "Adult Listing of Impairments."
8. http://www.ssa.gov/OP_Home/rulings/di/02/SSR82-62-di-02.html.

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

Advance Directives News

Terri's Legacy

By Ellen G. Makofsky

The Terri Schiavo case has cast a long shadow on the health care proxy. New York law provides that a properly drafted and executed health care proxy allows the designated agent to make any health care decision that the incapacitated principal could make.[1] The agent may make a wide range of decisions: what hospital; what doctor; what type of treatment; how aggressive that treatment should be; and finally, end of life decision-making. The agent is required to act according to the principal's wishes. Where the wishes are unknown a best interest standard must be employed except where the decision to be made involves artificial nutrition and hydration. In cases involving tube feeding, the agent must know and act according to the principal's wishes. Where the above requirements are met the power of the designated agent is absolute in New York State.

There is no requirement within the health care proxy law that an individual's wishes be memorialized in writing. Health care decision-making has many nuances. It was contemplated in creating the health care proxy law that the agent, a trusted family member or friend would have a full and complete conversation with the principal so that the agent could really understand what the family member or friend wanted in a wide range of situations. The clear advantage of authorizing a health care agent to act is that the principal has a living, breathing person with a brain who can evaluate the particular situation in light of the principal's articulated wishes and the available medical technology and expertise.

The health care proxy law was enacted to provide an alternative to the living will, which is not recognized by statute and requires judicial intervention when the static words of the document do not meet the particular situation presented. It was never intended that the health care proxy stand side by side with the living will. After the health care proxy law came into being, the option of the living will remained for those who had no appropriate health care agent to appoint.

Terri Schiavo, a Florida resident, had no advance directive in place. Florida law allows a family member to make surrogate health care decisions according to the incapacitated person's wishes when no individual was previously designated to make health care decisions. Terri's husband and parents each felt they knew what Terri would have wanted. When litigation failed to provide the decision Terri's parents were hoping for, they appealed to other branches of the government on both the state and federal levels. As a result the Florida legislature intervened, as did Florida's governor, and when this was unsuccessful, the Congress of the United States and the President became involved. This has set a dangerous precedent in undermining an individual's right to direct his or her own health care free of government intervention.

The health care proxy law works in New York. We cannot allow each branch of the government to weigh in on personal health care decisions made in good faith by a validly appointed health care agent. The legacy of Terri Schiavo should not be to weaken an individual's right to implement his or her own health care decisions but, rather, should be a wake-up call to all those who have neglected to execute a health care proxy.

Endnote

1. The statute requires that, at a minimum, the document identify the principal and agent and that the document indicate that the principal intends the agent to have the authority to make health care decisions on the principal's behalf. N.Y. Public Health Law § 2981(5). The health care proxy must be signed in the presence of two adult witnesses and the appointed health care agent may not serve as a witness. A statement from the witness that the principal appeared to execute the proxy willingly and free from duress must be incorporated into the health care proxy. N.Y. Public Health Law § 2981(2).

Ellen G. Makofsky is a *cum laude* graduate of Brooklyn Law School. She is a partner in the law firm of Raskin & Makofsky with offices in Garden City, New York. The firm's practice concentrates in elder law, estate planning and estate administration. Ms. Makofsky is Chair-Elect of the Elder Law Section of the New York State Bar Association ("NYSBA"). Ms. Makofsky has been certified as an Elder Law Attorney by the National Elder Law Foundation and is a member of the National Academy of Elder Law Attorneys, Inc. ("NAELA"). Ms. Makofsky has spoken on the radio and appeared on television, and is a frequent guest lecturer and workshop leader for professional and community groups.

Guardianship News

A Case Study—Article 81 and Mental Illness

By Robert Kruger

This article is a story about one case. It may, however, be valid to extrapolate from this case to other guardianships involving the mentally ill. The problems this case posed, and the ultimate solution, will probably resonate with many of you. How far one can generalize about guardianships for the mentally ill is unclear, since mental illness, in my experience, is not as well understood as dementia and, for me at least, is far less predictable.

The AIP is named H. She is in her early 50s, in the midst of a nasty divorce, extremely bright and manipulative, with a history of psychiatric problems. She has no children, two concerned siblings, an elderly mother and stepfather, and several cousins who are insightful and concerned.

The husband in this drama, after a 12-year marriage, walked out with complete control of the couple's substantial net worth, leaving H psychologically penniless if not literally so.

As I soon learned, her matrimonial counsel could not obtain meaningful guidance from her. She was delusional, imagining eavesdropping and surveillance equipment and cameras in the appliances in the marital apartment. The husband's matrimonial counsel was pushing hard for an answer (the husband was the plaintiff) and discovery and her attorney could not have a rational discourse with her.

I commenced a guardianship proceeding, using the anecdotal harvest the cousins had witnessed. The order to show cause contained a temporary restraining order preventing further proceedings in the matrimonial action.

The court evaluator was a mature and experienced attorney who was no stranger to the problems of the mentally ill. Indeed, our first conference focused on how one gets psychiatric help for H.

The problem of getting help for H was a recurring one in this matter, and I shall return to it at various points. Initially, as long as H was delusional, an involuntary hospitalization, to review, correct or change her medications, was on the table.

After H was served, she began to pull herself together. It took 10-14 days, but she found herself an attorney—a competent professional with a background in Article 81. She was able to accept suggestions from him that she would have rejected outright from her family.

For example, she was seen by an evaluating psychiatrist, not once, but several times. She was referred to a psychopharmacologist who changed her medications. She was referred to a treating psychiatrist for therapy on an ongoing basis. Parenthetically, her attorney, in my judgment, did a first-rate job for her.

"How far one can generalize about guardianships for the mentally ill is unclear, since mental illness, in my experience, is not as well understood as dementia and, for me at least, is far less predictable."

As she improved, the court evaluator changed her position. No longer was the court evaluator convinced that H needed a guardian. That was probably an accurate assessment at the time. Less persuasively, the court evaluator questioned whether H was mentally ill; now, she needed psychiatric assistance. And, amazingly, the motives of H's extended family were now being questioned, as if the delusional behavior could be rationalized as stress-related, disregarding a psychiatric history that, conservatively interpreted, was troubled. Now, H was the child of a religious conservative (not fundamentalist) Midwestern Protestant family; her behavior was perceived (as the court evaluator stated) to be rebellious rather than troubled.

I digress for a moment: H was able to sell her story to the court evaluator, with whom she spoke several times a week for hours at a time. In these conversations, H not only appeared to be rational, she probably was rational. The underlying question petitioner had was whether, when the pressure of a guardianship was removed, H would continue to be rational.

To return: Both the court evaluator and H's attorney, supported by considerable psychiatric evidence, were convinced that H did not require a guardian. As the hearing came closer, H's family and I agreed that a guardian was not required . . . but for somewhat different reasons.

It is not difficult to conclude that there is necessity for the appointment of a guardian when the guardian can impose a level of care on the IP. It is quite another matter when the guardian's power is limited to involuntary hospitalization or nothing.[1]

What powers would a guardian receive for someone like H? She can certainly choose her residence, her physicians and psychiatrists and her other health care providers. She can decide which health care providers to see and how often to see them. Would the guardian's powers be triggered by clear and convincing evidence that H had decompensated and was now mentally ill? If so, what would the guardian do with power over H? Would not the act of intervention bring her back to something approaching normality? And, when the threat had receded, would H not, again, be at risk?

My point is that many mentally ill persons, potential AIPs, are moving targets. Getting help for such individuals is a daunting task and whatever help is obtained has a very short shelf life indeed. If the family had succeeded in appointing a guardian for H, and at the end of this proceeding they did not know what he or she could do with the authority if it were granted, the guardian would have had the responsibility without the authority or ability to help H.

Ultimately, the proceeding was discontinued without prejudice. The family had, by instituting this proceeding, brought H to the point where she sought treatment. The proceeding can, by supplemented order to show cause, be reinstituted at any time. The threat of this may prove as useful as obtaining the relief sought, because H did not like the notion that a guardian could be appointed for her. Not one bit.

The post-discontinuance story remains to be written. The family hopes that H will continue with therapy and her medications. There is some indication, from H's mother, that she is not doing so, at least, not religiously doing so.

In conclusion, obviously, a guardianship is not a supple instrument for H, and probably, for many mentally ill persons. The AIP needs to continue treatment and take her medications and, unless you control the IP's comings and goings, there is no way short of involuntary hospitalization to compel treatment in Article 81.[2]

Secondly, by the time the hearing approaches, many AIPs will show well and the necessity for the appointment of a guardian will evaporate. What I did not expect was the court evaluator's bizarre shift to hostility to the family. At the court conference which resolved the matter, I asked her if she thought the family had acted in good faith by instituting this proceeding. The response was "yes" . . . a grudging "yes." I suspect, in this Manhattan case, ideology framed the response of this court evaluator, not reality.

"[M]any mentally ill persons, potential AIPs, are moving targets. Getting help for such individuals is a daunting task and whatever help is obtained has a very short shelf life indeed."

Endnotes

1. Mental Hygiene Law Article 9 ("Kendra's Law") may provide a more effective method of obtaining control of a mentally ill person who needs medication and who is a danger to herself or others. Article 81 may be overkill.
2. Psychotropic medication constitutes "major medical treatment" under MHL 81.03(i).

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

National Case News

By Brian Andrew Tully

This column addresses recent cases in jurisdictions other than New York. Questions or comments regarding this column may be sent to the author at bat@estateplanning-elderlaw.com.

The Estate of Cordellia Steffes v. State of Iowa and Iowa Department of Human Services, Iowa Court of Appeals, March 31, 2005

Cordellia Steffes and her husband owned two farms, and deeded these farms to their son, Alden. In ensuing litigation, the district court concluded that Cordellia had beneficial ownership of the farms, with Alden serving only as Trustee. The Department determined the trust value was an available resource; her countable resources exceeded $2,000, and disqualified her from receiving Medicaid assistance.

After a contested case proceeding, an Administrative Law Judge found that there was "no evidence of any intent that Alden had any discretion to convey the land back to Cordellia or her husband or to anyone other than the other children on the deaths of both Cordellia and her husband" and thus ruled the trusts assets did not disqualify Cordellia. The Department reversed the Administrative Law Judge and found that Mrs. Steffes was the trust's only beneficiary and nothing limited the amount of trust principal that could be made available to her. The district court affirmed. The estate appealed, arguing that Mrs. Steffes never received income, assets, or benefits from the trust, and the property was transferred into the trust more than five years before the receipt of Medicaid benefits.

The Court of Appeals of Iowa affirmed, and ruled that this was a "Medicaid qualifying trust" since she "may have been a beneficiary of the trust." The court held that the assets *were* available to her had she pursued her legal rights against the trustee and that the five-year look back period rules argued by the estate are inapplicable, as Cordellia retained a beneficial interest in the trust.

Mildred Lea Smith v. State of Louisiana Department of Health and Hospitals, Court of Appeals of Louisiana, March 2, 2005

A former revocable trust is not available to a Medicaid applicant because she, as the trust's surviving settlor, cannot revoke it due to her incapacity and the trust cannot be revoked under an existing power of attorney, and is now irrevocable.

The State of Louisiana Department of Health and Hospitals denied an application for Medicaid and

Long Term Care Benefits on grounds that the applicant was the settlor, trustee, and beneficiary of a revocable trust whose value exceeded the maximum resource limit for individuals. Under administrative appeal, an Administrative Law Judge (ALJ) affirmed the denial of benefits, concluding Ms. Smith had access to nine certificates of deposit in a revocable trust, at a value exceeding $2,000. The district court concluded that the trust was irrevocable, reversed the ALJ and ordered the Department to provide Medicaid benefits to Ms. Smith. The Department appealed.

The Court of Appeals affirmed the judgment of the district court and affirmed that the trust is irrevocable and not an available asset for Medicaid purposes. The court held that although the reading of the trust "implies that a surviving settlor has the power to revoke the Trust with notice to the beneficiaries, our research has revealed that the Trust appears to be irrevocable on the ground of Ms. Smith's apparent incompetency." Moreover, her daughter may not exercise a power of attorney to revoke the trust. Although there were no Louisiana cases on point, the court's research found that the rule at Common Law was that a guardian of an incompetent person does not have the power to revoke a trust for the ward unless such power is specifically provided to a guardian in the trust. The court ruled this trust was irrevocable.

In the Interest of R.F. North Dakota State Hospital v. R.F, Supreme Court of North Dakota, March 4, 2005

Patient, R.F., is a 64-year-old resident of Minnesota who is presently homeless and has bipolar disorder. Although R.F. had established history of willingly and properly caring for his bipolar disorder with medicine and professional treatment, evidence indicated that the patient had been recently diagnosed with early-stage dementia and his doctor was concerned that in the absence of the hospital's structure and monitoring, R.F. may fall victim to another dementia-related accident by continuing to self-med-

icate. Moreover, North Dakota State Hospital had not yet isolated the cause of R.F.'s dementia or prescribed proper medicine. In the hospital's action for involuntary commitment of R.F., evidence supported the trial court's finding that in-patient hospitalization was the least-restrictive condition necessary to achieve the purposes of treatment.

The legal standard for a least-restrictive treatment appeal requires the court to make a two-part inquiry: (1) whether a treatment program other than hospitalization is adequate to meet the individual's treatment needs; and (2) whether an alternative treatment program is sufficient to prevent harm or injuries which the individual may inflict upon himself or others. The court must find by clear and convincing evidence that alternative treatment is not adequate or hospitalization is the least restrictive alternative.

Lastly, the court wrote that R.F.'s homeless status was not the motivating factor in the district court's order. Rather, his homeless status merely indicated an "absence of an adequate support system through which he could combat dementia."

Kokoros v. Kokoros, et al., Middlesex, Massachusetts Probate & Family Court, February 8, 2005

In an estate's challenge to *inter vivos* transfers made by the holder of a power of attorney, the attorney-client privilege exists between the law firm that assisted with the transfers and the holder, not between the firm and the power of attorney's grantor.

Alexandra Lappas was appointed by her brother, Nicholas Kokoros, as his attorney in fact by a durable power of attorney executed in 1997. Ms. Lappas transferred Mr. Kokoros' property to herself and her siblings after Mr. Kokoros became ill in 2004. In April 2004, Mr. Kokoros died and his son George was appointed administrator of his father's estate. George wanted the transfers set aside, challenging them as fraudulent and breaches of fiduciary duty. George then waived the attorney-client privilege between Mr. Kokoros and the firm that had assisted Ms. Lappas in the transfers, allowing the firm to provide all documents regarding Mr. Kokoros that George had requested. The firm moved to quash the resulting deposition subpoenas, asserting that the privilege is between the firm and Ms. Lappas, not the firm and Mr. Kokoros.

The probate court agreed with the firm, noting there was no arrangement or communication between the firm and Mr. Kokoros in 2004. The court ruled that "the privilege runs to the individual seeking the legal advice or assistance, regardless of the capacity he or she may be acting under and, therefore, any communications between the holder and the firm are privileged."

James Day, by and through Arizona Department of Veterans' Services v. Arizona Health Care Cost Containment System Administration (AHCCCS), Court of Appeals of Arizona, March 31, 2005

James Day appealed a superior court judgment in favor of AHCCCS, which affirmed an AHCCCS administrative order that guardian and conservator fees are not "medically necessary" and are not included in the calculation of an AHCCCS recipient's share of cost. Mr. Day is an incapacitated single man receiving AHCCCS benefits from the Arizona Long Term Care System (ALTCS). The Arizona Department of Veterans' Services (Veterans) is the court-appointed guardian of Mr. Day and conservator of his estate. Mr. Day's ALTCS eligibility was reviewed in September of 2002 and he contended that, in calculating his share of the cost, veterans' fees should be deducted as necessary medical expenses not covered by ALTCS.

The category of medically necessary expenses is used to calculate the benefit recipient's contribution to his care. Medically necessary, as defined by the Arizona Administrative Code, is "a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse health conditions." The definition of "necessary medical care" was not met in this case. "Veterans may perform a necessary and very valuable service, but it does not perform a medical service recognized by Arizona law." Mr. Day nevertheless argued that the fees were "medical in nature" because Arizona law allows a court to appoint a guardian or conservator pursuant to a physician's examination and report. The court noted that this is required only to appoint a guardian.

Samuel Paschall v. District of Columbia Department of Health, District of Columbia Court of Appeals, April 7, 2005

Mr. Samuel Paschall was discharged from a Medicaid and Medicare certified nursing facility upon written notice that such discharge was necessary to protect him or other residents of the facility from injury. Mr. Paschall filed petition for review of an order of the District of Columbia Department of Health Administrative Law Judge (ALJ), which ruled that discharge notice was invalid, but that he lacked the authority to order Mr. Paschall's readmission.

The Court of Appeals held that the Nursing Home and Community Residents' Protection Act, authorizing a Superior Court judge to grant injunctive and equitable relief for violations of the Act and applicable regulations, did not preclude the ALJ from ordering readmission of Mr. Paschall. Furthermore, the ALJ had authority to order readmission of Mr. Paschall before a hearing, upon determining that the discharge was unlawful for failing to provide a location to which Mr. Paschall was to be discharged. This case was also remanded to permit the ALJ to determine whether Mr. Paschall continued to seek readmission or had relinquished his right to readmission, and whether his readmission could be achieved without endangering the health and safety of himself or other residents.

State of Idaho v. Estate of Joe Kaminsky, Supreme Court of the State of Idaho, March 30, 2005

Decedent received $54,067.59 in Medicaid benefits before his death on June 19, 2000. Decedent was survived by his wife and children. Over two and one half years after Mr. Kaminsky's death, the state Medicaid agency wrote to the decedent's children's lawyer stating that a claim existed against the decedent's estate, but that no demand for payment would be made so long as the decedent's widow was still alive. Two months later the children initiated a probate proceeding, had the decedent's will admitted (it provided for distribution of his entire estate to his children) and disallowed the Medicaid claim. The Medicaid agency filed a petition for allowance of the claim and the children objected that it was filed after the state's two-year statute of repose barring claims against decedents. The probate court dismissed the claim. The Medicaid Agency appealed and the State Supreme Court affirmed the dismissal, ruling that the ultimate time limit for filing of claims against decedents applies to the Medicaid claim just as to other creditors' claims. Although the Medicaid agency attempted to distinguish its intentions by insisting that it was not "making" a claim but merely "establishing" one, the high court rejected the distinction; the proper procedure, ruled the court, would be for the agency to establish the validity and amount of its claim within the time period even though it would not be permitted to collect on that claim until the widow's death.

Brian Andrew Tully is in private practice with offices in Huntington and Hauppauge, New York. He is certified as an elder law attorney by the National Elder Law Foundation and focuses his law practice on estate planning, elder law, Medicaid benefits and asset protection. His professional memberships include the New York State Bar Association's Elder Law Section where he is a member of the Committee on Long Term Care Reform, the National Academy of Elder Law Attorneys, the Suffolk and Nassau County Bars and the American Bar Association's Estate Planning Committee. He is also on the Board of Editors for the New York State Bar Association's *Elder Law Attorney* publication.

Mediation News

By Robert A. Grey

Welcome back to Elder Law Mediation! We actively solicit your mediation questions, comments and experiences, positive or negative. Please send them to Robert A. Grey, Esq., 38 Stiles Drive, Melville, NY 11747-1016 or GreyLaw@optonline.net.

Often, when preparing for a mediation session, I will study a number of quotations which I keep as references. I compile these quotations on an ongoing basis. I collect them for their wisdom and/or wit. They can help maintain or regain perspective, and they can encourage outside-the-box thinking and problem-solving. From time to time I would like to share them with you. Here a few that are particularly relevant to the elder law community. I hope you will find them as useful and enlightening as I do.

Time is the coin of your life. It is the only coin you have, and only you can determine how it will be spent. Be careful lest you let other people spend it for you.

—Carl Sandburg (1878-1967)

Time is the most valuable thing a man can spend.

—Theophrastus (300 BC-287 BC)
from Diogenes Laertius,
Lives of Eminent Philosophers

How old would you be if you didn't know how old you were?

—Satchel Paige

If I'd known I was gonna live this long I'd have taken better care of myself.

—Eubie Blake (on his 100th birthday)

Each day comes bearing its gifts. Untie the ribbons.

—Ann Schabacker

I'm sick and tired of being sick and tired.

—Fannie Lou Hamer

It takes some perspective to think in billions. Keep the following in mind:

One thousand seconds is about 17 minutes.

One million seconds is about eleven and a half days.

One billion seconds is about 32 years.

—Tim Weiner

A nickel ain't worth a dime anymore.

—Yogi Berra

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

Mr. Grey has experience as a guardian, court evaluator, guardian *ad litem* and attorney for AIPs in guardianship proceedings. He is the author of the chapter on "Mediation in Guardianship Practice" in NYSBA's *Guardianship Practice in New York State, 2004 Supplement*, and has given presentations on mediation to various law school, bar association and community groups. He is a member of the NYSBA Elder Law Section, NYSBA ADR Committee, Suffolk County Bar Association Elder Law Committee, Queens County Bar Association Elderly and the Disabled Committee, and the National Association of Elder Law Attorneys (NAELA).

Ethics News

By James H. Cahill, Jr.

A recent decision by the New York State Commission on Judicial Conduct revisits the issue of need for impartiality in the judicial process. Specifically, the Commission addressed the issue of a relationship between a judge and a party appearing before the judge, seeking relief. Concomitant with the issue of a personal relationship, the court commented on the propriety of a judge's appointment of that same party litigant as a guardian in a lucrative guardianship during the pendency of an action before her. Relying on well established ethical constraints caused by a relationship between a judge and an attorney, the Commission reviewed the issue of disqualification where a judge's impartiality might reasonably be questioned (Section 100.3[E][1] of the Rules Governing Judicial Conduct ["Rules"]).

In *In re Diane A. Lebedeff* (2), dated March 18, 2005, the State Commission of Judicial conduct rendered a decision highly critical of the judge's handling of a proceeding where she had a social and personal relationship with one of the parties while also engaging in "gossip" sessions with the party during the proceedings. The Commission further noted that the judge also awarded the party an appointment to a lucrative guardianship resulting in a fee of $84,000. At the heart of the Commission's decision is Section 100.3[E][1] of the Rules Governing Judicial Conduct which provides, in pertinent part, that "[a] judge's disqualification is required in any matter where the judge's impartiality might reasonably be questioned." In connection with the Commission's proceedings, the judge stipulated that she violated the standard by presiding over a personal injury case in which the co-plaintiff was Ravi Batra, an attorney with whom she had a significant social and professional relationship.

For more than five years, the judge respondent presided over and made numerous rulings in a case where Mr. Batra and his wife were seeking $80 million in damages. The Judge did not disclose her relationship with Mr. Batra, which included dinners together, visits to each others' homes, at least one joint family outing, and her continued social involvement with Mr. Batra during the pendency of his case. During the case, the Judge and Mr. Batra had lunch together, private meetings and conversations in court that included, on several occasions, the respondent specifically excusing the other attorneys in the case so that she could "gossip" privately with Mr. Batra.

The Commission determined that the judge's conduct created an appearance of impropriety in violation of ethical standards and demonstrated a glaring insensitivity of her duties to avoid even the appearance of impropriety. Under the circumstances, even if the judge had scrupulously avoided discussing the merits of Mr. Batra's case during their private conversations, the appearance of impropriety would be inevitable.

"If you have a social or professional relationship with a judge, it is probably best that another disinterested judge handle the case."

Coupled with the social relationship of the judge to Mr. Batra, the judge, during this same period, awarded Mr. Batra fiduciary appointments that included an appointment to a lucrative guardianship resulting in a fee of over $84,000. Reportedly, the judge approved Mr. Batra's bills for $400 per hour, nearly double the usual rate for such services.[1] The Commission concluded that the appointments compound the appearance that the judge could not be impartial in Mr. Batra's case. The award of a fiduciary appointment signifies a judge's confidence in the credibility and integrity of the appointee. In the litigation before the judge, she was necessarily required to evaluate Mr. Batra's credibility and should have recognized her ethical obligation not to preside in the case.

Moreover, the Commission examined the nature of the proceeding involving Mr. Batra, noting that in one ruling the judge granted Mr. Batra's motion for sanctions against one of his adversaries. Another of the judge's rulings overturned by the Appellate Division included a decision suggesting that the ruling showed a lack of "objectiv[ity]" by respondent. (Following that ruling, the case was transferred to another judge.) Because of her relationship with Mr. Batra, respondent's rulings in his favor raise a suspicion that she was influenced by personal considerations. Such an appearance is inimical to public confidence in the integrity and impartiality of the judiciary, as respondent should have recognized. Her apparent

failure to realize that her relationship with Mr. Batra would raise the question whether her rulings were based solely on the merits is shocking and suggests an unacceptable insensitivity to judicial ethics.

The Commission noted that the respondent judge had previously been censured for creating an appearance of impropriety by failing to pay her accountant for tax preparation services over the same period that she was appointing the accountant as a fiduciary and approving the accountant's compensation. *In re Lebedeff*, 2004 Annual Report 128 (Comm. on Judicial Conduct). The Commission concluded that the judge's "dereliction of her ethical responsibilities created an appearance of impropriety" and "jeopardizes the public's respect for the judiciary as a whole, which is essential to the administration of justice."

Needless to say, the decision by the Judicial Conduct Commission sends a reminder of the need for judicial impartiality. If you have a social or professional relationship with a judge, it is probably best that another disinterested judge handle the case.

Endnote

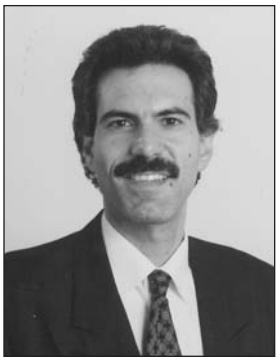
1. *New York Times*, April 8, 2005, Andy Newman.

James H. Cahill, Jr. is a member of the firm of Cahill & Cahill, P.C. founded in 1905 with offices in Brooklyn, New York. The firm's practice concentrates in estate litigation, estate administration, elder law and estate planning. Mr. Cahill serves as vice chair of the Brooklyn Bar Association Elder Law Section and teaches at New York University as an adjunct instructor. He frequently speaks and writes on topics within his practice areas.

Pearls and Gems

By Ronald A. Fatoullah and David Goldfarb

Eliminate Spousal Suits With Annuities



Ronald A. Fatoullah

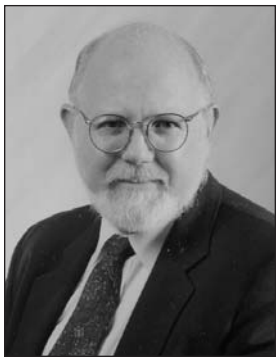
When a community spouse signs a spousal refusal, she can be sued for recovery by the local Department of Social Services. With county executives desperate to reduce Medicaid expenses, these suits will likely become more common, necessitating advance planning for protection of the well spouse's assets. If a well spouse purchases an actuarially sound irrevocable immediate annuity in accordance with her life expectancy pursuant to HCFA Transmittal 64 charts (later included as an attachment to 96 ADM 8 in New York), she can reduce her assets without incurring a period of ineligibility for the applying spouse.

When advising a client to purchase an annuity, there are several important considerations. First and foremost, in order for the asset to be unavailable, the annuity must be irrevocable. The policy should include a provision regarding irrevocability to assure non-availability. Second, the term of the policy cannot exceed the individual's life expectancy. If the term of the annuity exceeds the individual's life expectancy, it will be considered a partial transfer for Medicaid purposes. For example, if a community spouse has a life expectancy of 8 years, but purchases an irrevocable immediate annuity for a term of 16 years, then she will be deemed to have transferred 1/2 of the assets.

The annuity policy should also contain language stating that there is no cash value or loan value and that payments made may not be amended or accelerated. Clearly, if the policy can be surrendered for cash, the asset is available.

The New York State Department of Insurance has stringent rules about what language is permissible in annuity policies. In order to protect prospective insured individuals the Department does not allow language that prohibits assignment. Florida rules, however, allow for clear language prohibiting assignment. While New York policies may be irrevocable, most New York policies have provisions that indirectly imply that assignment is permissible.

However, as stated above, Florida State Department of Insurance is not as stringent regarding "Medicaid language." As a result, the language on many Florida-based policies is very clear in the endorsement. Sample language from a Florida policy includes "the annuity is non-transferable, non-assignable, non-commutable, non-surrenderable, totally and permanently irrevocable and has no cash value." If possible, your client may opt for a Florida-based annuity to obtain such language.



David Goldfarb

Finally, it is helpful to include language that the policy is non-commutable, which indicates that you cannot change the policy.

Make sure that the annuity reduces the community spouse's assets to the community spouse resource allowance ("CSRA") or below. Currently, the CSRA is 1/2 of the resources of the spouses with a maximum of $95,100 and a floor of $74,820. Therefore, the community spouse should reduce the community spouse's resources to $74,820 rather than $95,100.

For example, an 80-year-old community spouse (female) who has $174,820 in assets ($100,000 in excess of the CSRA) can purchase an irrevocable immediate annuity for $100,000. Her life expectancy is 9.11 years. If the interest rate of the annuity is 4.5%, her monthly payments from the annuity would be approximately $1,128 per month. If, after purchasing the annuity, her income exceeds the MMMNA (currently $2,378 per month), she will be asked for a contribution of 25% of her income over $2,378 towards the cost of her husband's care.

Of course, the annuity option is not appropriate for all community spouses with assets over the CSRA. Each case must be analyzed individually. The age of the community spouse and the extent of her assets over the CSRA are determining factors.

Update on Supplemental Needs Trusts

Sanango v. N.Y. City Health & Hosp. Corp.

In *Sanango v. N.Y. City Health & Hosp. Corp*., 6 A.D.3d 519, 775 N.Y.S.2d 343 (2d Dep't 2004), the Appellate Division, Second Department, held that Medicaid's right to a payback from a self settled trust cannot be defeated by having a structured settlement or annuity pay into a supplemental needs trust, but have a separately designated remainderman. The

court below had allowed an annuity to be purchased which provided payments for the life of the beneficiary into the SNT, with guaranteed payments for 240 months. The court below directed that, in the event of the beneficiary's death prior to the receipt of all guaranteed payments, payments would be made to the beneficiary's estate and not into the SNT. The Appellate Division reversed, holding that the arrangement prejudiced and impaired Medicaid's right to receive reimbursement up to the total value of all medical assistance provided.

The New York City Human Resources Administration takes the position that *Sanango* has implications beyond a structured settlement. For example, it objects to an SNT purchasing a homestead for the beneficiary and putting the real estate or coop in the name of the beneficiary. Advocates, however, may question whether *Sanango* prohibits having any large asset like a house held "outside" the SNT.

Income Into an Individual SNT or a Pooled Trust

A supplemental needs trust may be funded with income, except Supplemental Security Income (SSI), and the excess income transferred into the trust will not count for purposes of Medicaid eligibility. 96 ADM-8 at p.8, § 7(b).

In *In re Kennedy*, 3 Misc. 3d 907, 779 N.Y.S.2d 346 (Sur. Ct. Nassau County 2004), the Surrogate's Court, Nassau County, approved the establishment of a supplemental needs trust funded solely with social security disability payments. The court held that although the spend-down requirement of N.Y. Soc. Serv. Law § 366(2)(a)(7) appeared to be inconsistent with the supplemental needs trust provisions of N.Y. Soc. Serv. Law § 366(2)(b)(2)(iii), they should nevertheless be construed together and the court therefore considered the SNT as an exception to the general Medicaid rules, including the spend-down rules. *Id*. at 910, 348.

A disabled individual over the age of 65 can put income into a pooled supplemental needs trust (for example, NYSARC Trust II). However, because of transfer penalties for institutional care for persons over the age of 65, this will only assist someone who requires community-based care such as home care services.

Persons over 65 receiving Medicaid will usually not have been determined to be disabled. The New York State Department of Health requires a separate disability determination in such cases. 05 OMM/INF-1. Disability determinations for all individuals who are over age 65 and are contributing to a pooled trust are to be performed by the State Disability Review Team in Albany. Specific instructions are in 05 OMM/INF-5. The forms required are a Transmittal Sheet (LDSS-654), a Disability Interview Form (DSS-1151) filled out at the face-to-face interview, a release of medical evidence form, and appropriate sections of the "Medical Report for Determination of Disability" Form LDSS-486T. The M-11 Q cannot be used for this determination of disability.

The state takes the position that income diverted to an SNT will not be disregarded for purposes of chronic care budgeting (nursing home care), even where the beneficiary is under 65 and there would be no transfer penalty. 05 OMM/INF-5. This is the same position taken in GIS 04 MA/027 (11/8/04) regarding the exclusion for income earned on certain exempt resources. This is apparently based on 42 CFR 435.832(c), which states that only specific enumerated deductions apply to post-eligibility institutional care budgeting and "[i]ncome that was disregarded in determining eligibility must be considered in this process." See also 42 U.S.C. § 1396a(r)(1)(A).

Advocates however, claim the above position is incorrect for two reasons: (1) if the income is irrevocably assigned to the trust it is no longer income which comes under the disregard rules; (2) the chronic care budgeting rules are inconsistent with the later laws providing for exempt trusts and as the *Kennedy* case and the State Medicaid Manual point out, the laws must be read so that they are not a nullity. CMS State Medicaid Manual § 3259.7.

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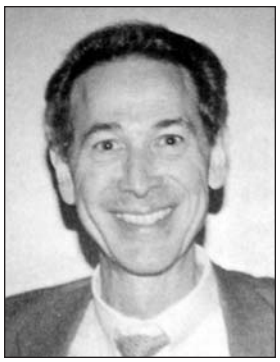
Bonus News 1

Who Cares About Oral Health For Seniors? Columbia University School of Dental & Oral Surgery

By Marc Crawford Leavitt



The short answer is almost nobody. But Columbia University's School of Dental & Oral Surgery (SDOS) via its Senior Oral Health Initiative (SOHI), working together with partners like the Consumers Union Center for Consumer Health Choices, is trying to change that. The longer answer is that elder lawyers and the rest of the country should understand why oral health care for seniors, and potential access difficulties, are important.

The U.S. Surgeon General has deplored the lack of attention to oral health, even by the mainstream medical establishment, saying in 2000, *"[We must] reconnect the mouth to the rest of the body in health policies and programs."* Care of older persons is often disorganized and confusing. Many competent and compassionate doctors, family members and even dentists do not understand the special body of knowledge required for seniors. The Baby Boom generation of 76 million is aging, and by 2030 20% of Americans will be over 65. But as America's elderly population continues to grow, its dental and oral health needs have received little attention and almost no public policy interventions. Even though greater percentages of seniors now retain their teeth compared to earlier generations, significant oral health problems still threaten their well-being and impact quality of life.

In our practices as we meet with seniors and families, we often interface with medical professionals, institutional staff, and social workers, as well as insurance and financial advisors. We know that the best interests of our clients are served by our broad awareness of interrelated issues. Our awareness of senior oral health issues, both with our client families and in our communities, can enhance the service we provide. Have you sat with clients who are in constant discomfort or can only eat baby food because ill-fitting dentures aren't adjusted? Or they won't go to church because of embarrassment about bad breath? Oral disease and conditions can have a profound impact on pain, self-esteem and difficulty with eating and even smiling. Asking a family when their loved one last went to a dentist can have positive results, including prevention of serious health problems.

Did you know that:

- Gum disease can increase vascular problems such as stroke and heart attacks.
- Medications often reduce salivary flow that in turn has detrimental effects on teeth, gums and personal comfort.
- Teeth and gum problems are perhaps the most common health complaint of seniors.
- Quality of life and motivation are significantly affected by oral health.
- Only 22% of seniors are estimated to have private dental insurance.
- Medicare does not cover dental care.
- Medicaid covers limited adult dental care in eight states only (including N.Y.) and nothing elsewhere.
- Home Care attendants and nurses in long-term care are not even trained to assist in brushing teeth.

Columbia SDOS has a Senior Oral Health Care Initiative (SOHI) with four parts:

1. **Education:** Training dentists, hygienists and nurses in the special issues regarding seniors. Developing fellowships to improve treatment, training and public advocacy. Training home attendants and family members about the importance of brushing teeth and awareness of oral health issues and the need for appropriate referral and treatment. Access limitations and transportation problems for seniors, including the home-bound and institutionalized, are addressed.
2. **Service:** Columbia faculty and students provide direct oral health care to seniors via a mobile dental clinic that visits senior centers and several northern Manhattan locations. SDOS created the Thelma Adair Center in

Harlem as a joint medical/dental facility in a naturally occurring retirement community (NORC).

- Isabella Home Care Connection. This model program involves training nurses to, in turn, train home care attendants and family members.

3. **Research:**

   - SDOS is carrying out studies of various conditions special to seniors.
   - The SDOS Behavioral Science Program is studying and addressing many issues, including the need to change the protocols for oral health assessments, provider training and case management.
   - Columbia's School of Architecture is involved in access issues via a Geographic Information System (GIS) mapping program that is highlighting the mismatch between provider locations and where seniors reside.
   - Together with Consumers Union's Center for Consumer Health Choices, efforts are underway to enable informed consumer choice via evaluations of insurers, providers, and products and promote cost-effective solutions to health issues affecting seniors.

4. **Policy:** Together with Columbia's Mailman School of Public Health, SDOS is promoting several policy goals.

   - Overall, provision of oral health care and its financing must be integrated with the mechanisms to ensure overall health and well-being for the elderly.
   - Primary health care providers and geriatricians must be educated about the medical, functional, emotional, and social consequences of oral diseases and dysfunction and the need for regular screening and preventive education.
   - Medicare should provide dental coverage as part of Supplemental Medicare, and this would reduce the cost of more extensive health interventions.
   - Medicaid should retain adult dental coverage.
   - National standards for oral health care and benchmarks for senior oral health should be developed.

The Editorial in the May 2004 issue of the *American Journal of Public Health*, with four articles by Columbia SDOS faculty, states:

> Priorities including promoting collaborations among other health care providers who routinely treat seniors with a focus on educating them about oral disease prevention and referral for treatment, developing and implementing relatively inexpensive preventive procedures and protocols for seniors who have problems accessing care, and formally training new generations of dentists and other health care providers to meet the needs of elderly . . . [Dr. Ira Lamster and Dr. Mary Northridge].

Dean Lamster was recently featured with Dr. Max Gomez on television regarding the SOHI program.

In sum, better oral health for seniors reduces more significant medical problems, saves money, and improves quality of life. As advocates for individual clients and state and national policy, the elder law Bar should be aware of and promote the importance of addressing senior oral health. Contact Associate Dean Dr. Stephen Marshall at 212-305-0764 or sm15@columbia.edu for information about dental and oral health programs and training; contact Dr. Kavita Ahluwalia at 212-304-7184 or kpa8@columbia.edu about training for nurses, home care attendants and families.

The American Dental Association's Give Kids a Smile program recently featured Columbia's care of underserved youngsters on television with Al Roker. Your prompting of clients and families to address oral health issues can literally result in a healthy and pain-free smile!

Marc Crawford Leavitt is a partner of the law firm of Leavitt, Kerson & Duane and a member of the Advisory Committee of Columbia SDOS. His late father, Prof. Joseph M. Leavitt, was the founding chair of the Division of Endodontics in the 1950s and largely responsible for root canal therapy becoming the standard alternative to tooth extraction.

Bonus News 2

Best Employment Practices

By Robert Ottinger

This article outlines three of the most common situations that create employment-related legal problems for businesses. The big three are (1) terminating an employee, (2) implementing and maintaining anti-discrimination and harassment policies and procedures, and (3) the payment of overtime wages. Each of these situations, and solutions to avoid these problems, are explained below.

1. Termination

The termination of an individual's employment requires careful planning to avoid legal problems. Unless an employee has a contract, an employee serves at the "will" of the employer and can be terminated at any time for any reason as long as the reason is not discriminatory. The termination will be deemed discriminatory if it is based, in part, on an employee's race, age, gender, disability, or religion.[1]

The best way to avoid legal trouble is to have a solid and well documented non-discriminatory reason for the termination. If the termination is based on an employee's poor performance, there should be a record of the performance problems. The record can be a written chronology detailing each instance of poor performance, culminating in the decision to terminate the employee. If the decision to terminate the employee was based on business reorganization or cost cuts, then evidence of this will need to be produced. The key is to create a written record that clearly demonstrates the reasons why the employee was terminated. There is no magic formula for this. Use common sense—just record the reason for terminating the employee and keep the record in a safe place.

Maintaining a clear record of each termination is vital. This information will be used to defend any legal action that arises from the termination. If the company can establish that it had a solid and well supported business reason for the termination, the company is likely to prevail. Moreover, the company's record of termination can be used to deter any legal action by convincing the employee, or the employee's lawyer, at the outset that the claim is without merit.

After deciding to terminate an employee, keep it confidential. The termination meeting should be kept short. Briefly summarize why the employee is being terminated and cite specific examples including any prior warnings or the failure to reach goals and objectives. If the employee has been with your company for several years, consider a severance payment. Severance payments will prevent the terminated employee from suing if an appropriate release of claims is included in the severance agreement. Many companies offer one month of severance for each year of employment for upper management employees, two weeks' severance pay per year for mid-management employees, and one week per year for administrative and support employees. Subsequent references provided to potential employers should be limited to confirming the individual's dates of employment and salary.

2. Discrimination and Harassment Policies

Employers must maintain and enforce anti-discrimination and harassment policies. These policies should be provided to each employee and a copy of a signed acknowledgment and receipt of the policies should be kept. The policies must provide a complaint procedure for employees to report discrimination or harassment. The policy should designate several different contact people to receive such complaints. It is crucial for employers to clearly establish and maintain a workable complaint procedure. An employer can face substantial liability if the complaint procedure fails to provide an employee with an effective avenue for help and support if he or she is subjected to discrimination or harassment.

If an employee reports potential discrimination or unlawful harassment, the employer must immediately investigate the complaint. If the complaint involves a supervisor or manager harassing or discriminating against a subordinate, the company must separate the individuals until the matter is resolved. The company must take immediate and effective action to prevent any continued harm to the employee. This action will protect potential victims of harassment or discrimination and limit the company's potential legal liability.

Employers must also ensure that the complaining employee is not subject to retaliation. Retaliating against an employee who has complained of discrimination, harassment, or any other protected activity is prohibited. Retaliation cases can result in large verdicts or settlements.

3. Overtime

Another common area of liability for employers arises from the overtime laws. Employers must pay overtime at a rate of one and one-half times an employee's regular rate for hours worked in excess of 40 per week. For example, if an employee normally earns $20 an hour, the employer must pay this employee at the rate of $30 per hour for each hour worked over 40 per week. The failure to properly pay overtime wages can result in substantial penalties and legal fees.

"White collar" employees are typically not eligible for overtime pay. Misclassifying employees as "white collar" or as otherwise exempt from the overtime laws is a common mistake. Administrative, executive, professional and outside sales employees are generally exempt from the requirement to pay overtime. However, if questions arise, it is best to seek legal advice and handle the issue proactively. If an employer misclassifies and fails to pay overtime to an employee, or even worse, a group of employees, then the employer may have to pay the unpaid overtime amount, plus a penalty equal to twice that amount and the legal fees incurred by the employee.

The big three—terminating an employee, implementing and maintaining anti-discrimination and harassment policies and procedures, and the payment of overtime wages—can produce costly and time-consuming legal problems if not handled properly. But, with advance planning, these problems can easily be avoided.

Endnote

1. Certain states, such as New York, forbid discrimination based on a person's sexual orientation. Many others do not.

Robert Ottinger practices employment law with offices in Manhattan.

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