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Preserving Judicial Independence

The need for an independent Judiciary is as important today as it was in our nation’s infancy, when Thomas Jefferson protested, in the Declaration of Independence, that King George III “made Judges dependent on his will alone for the tenure of their offices, and the amount and payment of their salaries.” The need for an independent Judiciary was so fundamental to the foundation of our democracy, in fact, that our Founding Fathers codified the concept in the U.S. Constitution by providing provisions for life tenure and salary protection to members of the bench.

New Jersey’s modern constitution, crafted at the 1947 Constitutional Convention, provides for a strong and independent judicial branch of our state government. An independent Judiciary ensures continuity, stability and impartiality in our legal system. Traditionally, judicial candidates have been evaluated on factors including integrity, legal knowledge and ability, temperament, diligence and the ability to remain fair and impartial.

The New Jersey State Bar Association has for many years been a staunch protector of and advocate for judicial independence. When the United States or the New Jersey State Senate has acted in a manner that threatens judicial independence, we have spoken out. When judicial decisions are unfairly criticized, we have defended judges from harsh and inflammatory attacks. Judges are sometimes called upon to make unpopular decisions in support of the constitutional protections afforded all of us.

Last year, the state of New Jersey faced a challenge to judicial independence when the State Senate threatened extensive hearings to contest the reappointment of Supreme Court Justice Barry Albin. This past May, Governor Chris Christie chose not to reappoint Justice John Wallace Jr. The decision regarding Justice Wallace marked the first time a New Jersey Supreme Court justice seeking reappointment was denied by a governor since the state’s constitution was adopted in 1949.

In both instances, the New Jersey State Bar Association played an active role in fighting for reappointment of our sitting justices, an essential step toward maintaining the nationally recognized leadership of our state courts. Our actions should have come as no surprise to those familiar with the state bar’s commitment to a fair and impartial bench. In fact, since 1969 the NJSBA has had an important role in evaluating candidates for the Judiciary through its compact with the Governor’s Office to provide a nonpartisan evaluation of candidates for the bench by its Judicial and Prosecutorial Appointments Committee (JPAC).

The issue of judicial independence remains in the forefront, and was the subject of an event held on June 22 cosponsored by the New Jersey State Bar Association, the Garden State Bar Association, the Hispanic Bar Association of New Jersey, the Association of Black Women Lawyers, the Asian Pacific American Lawyers Association of New Jersey and the American Civil Liberties Union of New Jersey. This free symposium, titled “New Jersey at a Crossroads—A Crisis in Judicial Independence,” featured an all-star panel of judges, lawyers and academics.

Rest assured in the coming year, and beyond, we will continue to focus our attention on preserving the independence the legal profession and New Jersey’s citizens have come to expect from the state’s Judiciary. As Thomas Jefferson himself first publicly proclaimed, this nation’s ability to fairly administer justice depends upon it.
twenty-five years ago, this magazine published a special issue titled “Law and Aging,” designed to stimulate the ‘greening’ of Garden State lawyers to the ‘graying’ of New Jersey. Although lawyers recognized that demographics would impact their practices, they believed legal problems of older adults could fit into a general, trusts and estates, or family law practice. Later that year, the trustees of the New Jersey State Bar Association approved creation of a special Aging and the Law Committee.

When the new bar headquarters opened two years later in New Brunswick, the Institute for Continuing Legal Education offered a seminar titled “Elder Law: It Ain’t Just Wills.” A record-breaking, overflow crowd had to be accommodated with piped-in audio in another room. Elder law, at the time not yet fully delineated, had, nevertheless, come of age. The committee became the Elder Law Section in the early 1990s, and later was renamed the Elder and Disability Law Section to accommodate the fastest-growing segment of the disabled population—the elderly—as well as their children. Older parents are forever concerned about who will take care of their disabled children when they are gone.

Firms and generalists recognize they can no longer conduct business as usual with their older clients whose legal needs often go beyond the tools at a lawyer’s disposal. They must consider complex federal and state statutes, regulations, both judicial and administrative law cases, unpublished opinions, and public and private institutions to which older Americans are beholden for their daily existence.

A federal judge once described the elder law practice as the “general store for the elderly and disabled.” This issue of New Jersey Lawyer Magazine is designed to introduce you to the broad range of issues that a full-service elder law practice may deal with. We are privileged to present the writings of past and current chairs of the section, as well as other well-known and highly experienced practitioners. We hope this issue stimulates your interest in this area of the law.”

Marilyn Askin phased out her elder law practice in 2000 to become president of AARP-NJ, and is currently the organization’s chief legislative advocate. In 1985, she founded what is now the Elder & Disabilities Law Section of the New Jersey State Bar Association and received the section’s first annual Lifetime Achievement Award, named in her honor. She has taught elder law and social welfare legislation at Rutgers Law School, Newark, for the past 26 years.

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Preserving the Primary Residence
The Minefield of Real Estate Transactions in Elder Law Planning

by Linda S. Ershow-Levenberg

Real property frequently comprises the largest asset in the portfolio of an individual who consults with an attorney about elder law planning. More often than not, this property is the primary residence of the client and other family members. Clients or their children will ask the attorney whether or not they should give the house to their children to prevent the nursing home from getting it. They ask this because their neighbor told them they should take this step, or because one of their child’s friends heard somewhere that they need to do this. There is never a simple answer to the inquiry, for one size does not fit all when it comes to elder law planning.

When a client asks about a real estate conveyance in the elder law context, consider:

- the impact on the elder’s legal right to remain in the home
- the impact on a Medicaid application for either at-home or institutional services
- the impact on income taxes of both the transferor and the transferee
- the impact on the elder’s financial and practical ability to remain in the home
- the impact on the elder’s estate plan
- the impact of present and future liens and mortgages

These considerations could also be stated as:

- Which legal rights in the property will be lost, and which ones retained? Is there a safer alternative than an outright transfer, such as creating a different form of ownership?
- Is the conveyance a gift, and if so what is its value? What will be the Medicaid transfer penalty? Is this the right time to complete the transaction? Is this property interest a countable resource or an excludable resource for Medicaid purposes? Does this property interest entail an income stream that is countable for Medicaid purposes?
- Will any tax benefits be lost, and will the transferee acquire income tax obligations such as capital gains taxes that can be avoided?
- Will the elder’s practical ability to remain in the home be in jeopardy because of a shortage of liquid assets and the loss of the ability to draw out the equity in the home via such vehicles as a reverse mortgage?
- Will this transfer disrupt the elder’s testamentary plan by disproportionately shifting assets, e.g., to one person although the elder wants a group of people to share the estate equally?
- Will this transaction cause existing mortgages to be called? Will it remove the risk of a future Medicaid lien?

This article presumes there is someone with legal authority to transfer the real estate by gift. If the elder no longer has the legal capacity to do so, there must be a valid durable power of attorney with gifting powers that are sufficient to accomplish the specific transfer in question. If there is no power of attorney, consideration must be given to seeking legal guardianship and obtaining court authorization to make the transfer.

Getting Started: Preliminary Factual Data

When evaluating the pros and cons of a property transfer in the elder care context, the following data will be important:

- How exactly is the property titled, and what is its value?
- Are there any liens against the property?
- Do all of the owners live in the home?
- What is the age and health of the property owner (elder)?
• What is the total of liquid assets available to the property owner?
• How do the property owner’s monthly expenses compare to his or her monthly income?
• Is there a caregiver child in the home? How long has he or she been providing care to the parent?
• How soon will long-term care be needed?
• Is there a sibling living in the home? Is this person an owner?
• Is there a spouse? Will the spouse remain in the home?
• Is there an adult disabled child who will continue to live in the home?
• What is the plan if the property owner ever needs around-the-clock care? Will he or she prefer to stay home, or to move into an assisted-living or other facility?
• How reliable and trustworthy are the homeowner’s relationships with the children and their spouses? Do they have any marital, employment or creditor problems among them?
• Does the property provide rental income on which the elder depends?

The Impact on the Elder’s Estate Plan

Not infrequently, an elder carefully explains that his or her desire is for the house and other property to be divided equally among all of the children or some other group of heirs. Upon examination, however, it sometimes turns out that the estate is mostly comprised of non-probate assets, which have somehow ended up disproportionately in the name of one or two members of the group, whether as co-owners or as death beneficiaries. Sometimes this is intentional; the elder may want to leave everything to just a few, hoping they will ‘take care of’ the others, or may want the whole group to divide the assets among themselves after the elder is gone. As often as not, however, elders simply did not understand that beneficiary designations such as P.O.D. (payable on death) or I.T.E. (in trust for) control the disposition of an asset despite contrary instructions in the will.1

This is also often the case with respect to joint ownership of real estate. As title is practically conclusive of ownership, and transfers between and among the class create gift and estate tax problems of their own, failure to carefully plan and failure to adjust the probate assets and non-probate assets could be creating problems that are entirely avoidable.

Transfer of real estate to one member of the class may be an exempt transfer for Medicaid purposes. The elder needs to be advised, however, of the impact this may have on his or her overall estate plan, so appropriate adjustments can be made.

The Impact on the Elder’s Legal Right to Remain in the Home

It is important to consider whether the elder’s legal right to remain in the home could be in jeopardy if anything happens to the transferee. For example, what would happen if:

• The person who becomes the owner of the house does not live there, and has to file for bankruptcy.
• The new owner (with or without a spouse) does not want the elder(s) to remain there or wants to sell.
• The new owner is sued and his or her interest in the house is attached by creditors.
• The new owner dies and the house passes through his or her estate to new owners, or must be sold to pay inheritance taxes.
• The new owner gets divorced and must provide property for equitable distribution.

While ‘protecting’ the full value of the home for the new owner, outright transfer of one’s entire interest in the primary residence creates substantial legal risk should any of the above situations occur. These risks can be reduced by considering such mechanisms as a transfer with a retained life estate. The transferee would be receiving a ‘remainder interest’ in the property subject to the life estate, and consequently anyone succeeding to the rights of that remainderman would also have an interest subject to the life estate.

The property could not be sold during the life tenant’s lifetime without his or her joining in the deed.2 The life tenant would receive a pro rata share of the proceeds and could apply his or her capital gains exclusion if statutory criteria are met.3 Along with having the beneficial use and enjoyment of the property, the life tenant retains the legal obligation to pay for repairs, maintenance, taxes and the like on the property, and has the right to receive the rents, if any. Benefits such as senior citizen tax abatements, the ability to procure a reverse mortgage loan, and the capital gains exclusion on the sale of a primary residence, are also retained. However, the remaindermen need to understand they do not own 100 percent of the property value during the life tenant’s lifetime, even if the life tenant moves out.

The Impact on Medicaid Eligibility

A person can apply for Medicaid to pay for nursing home care or care in the home when the countable, available resources have been reduced to $2,000 plus an allowance for the community spouse, called the community spouse resource allowance (CSRA).4 The transfer of any interest in property for less than fair market consideration, if made within the five years prior to applying for Medicaid, will trigger a disqualification period known as a transfer penalty, unless the property was the primary residence and was transferred to one of a limited category of transferees.5
The result of this disqualification is that Medicaid will not pay for the care for a specified period of time, called the transfer penalty period, regardless of poverty or medical necessity. The penalty begins to run when the person is in a nursing home, applies for Medicaid, and is “otherwise eligible.”

The House as a Countable or Excludable Resource Under the Medicaid Program

As a general rule, all available real property is counted as a resource when applying for Medicaid, to the extent of the individual’s ownership. However, although the primary residence is counted as a resource when applying for Medicaid, to the extent of the individual’s ownership, it is excluded as a resource if it is occupied by the community spouse. If the house is not occupied by such a person, it is excluded from consideration temporarily—usually for six months—but if the individual cannot return home and continues to require Medicaid benefits, it must be listed for sale at that point.

When the home is occupied by nonowner family members other than the spouse, the practices of the county welfare agencies vary regarding whether the property must be listed for sale. When the property is occupied by co-owner family members, or by a sibling with an equity interest, a disabled family member or a minor child at the time of the Medicaid application, typically there is no requirement that the property be immediately listed for sale. In the case of the Global Options for Long-Term Care home care program, the house may be retained.

If the elder is applying for Medicaid, the family may want to sell the property, but they also may want to consider keeping it and renting it out, particularly if the elder retains a life estate. The property will have a step-up in basis at the elder’s death, and the life estate will evaporate. Under current law, there is no Medicaid lien against the property if all the elder held at the time of death was a life estate that extinguished at death. The net rental income after expenses, if any, would be counted as part of the Medicaid recipient’s income.

The fact that the property may be excludable under certain circumstances—such as when there is a spouse living in the home—does not mean the home can necessarily be transferred by the elder to someone else without incurring a transfer penalty.

Medicaid Transfer Penalties

Since possession of the real property creates the risk that it will have to be sold to pay for care, elders may want to transfer that property in order to protect it for their heirs or co-owners. Transfer of the complete interest in real property as a gift within five years preceding a Medicaid application generally causes a lengthy transfer penalty period. If partial interests are transferred, pro rata values are assigned to the amount of the transfer penalty. In a transfer with a retained life estate, actuarial tables published by Social Security dictate the value of the transfer.

The issue is, if the elder transfers the house by gift and later needs around-the-clock care or nursing home care, will there be a way to pay for it privately during the transfer penalty period until he or she can be eligible for Medicaid? Currently, nursing home care costs between $8,000 and $10,000 per month, and not much less in one’s own home. The new owner of the house is at liberty to sell, mortgage, or give back the property to pay for the care, but certainly has no legal obligation to do so.

Some Transfers Cause No Penalties

There are some exceptions to the transfer penalty rules with respect to gifts of the primary residence. The primary residence may be transferred to the following categories of recipients without incurring any transfer penalty at all: a spouse, a child under age 21, a child of any age who is blind or permanently disabled, a sibling who has resided in the home for one year or more and already had an equity interest in the home, and a caregiver child (not a grandchild or other relation) who has resided in the home and provided essential and substantial care giving for two years or more prior to institutionalization. Transfers of any real property to a trust for the “sole benefit of” the spouse or a disabled individual under age 65, can also qualify as exempt transfers, as long as all of the criteria of the regulations are satisfied.

It is generally advisable to transfer the residence to the community spouse. If the community spouse later sells the property, he or she will be able to retain all of the proceeds of the sale.

Timing is very important when considering transfers to a caregiver child. Transfer of the property to a caregiver child at the time of institutionalization is an exempt transfer; transfer of that property at a time that is unrelated to an application for Medicaid will likely cause a period of disqualification that will begin to run after the individual is already in the facility and has applied for Medicaid. Thus, if there is a caregiver child living in the home, the elder should avoid transferring the house prematurely, as he or she could be incurring a transfer penalty that could be avoided if the transfer does not take place until the last minute.

The Impact on the Elder’s Financial and Practical Ability to Remain in the Home; Reverse Mortgages

For elders of nominal means, the equity in their home may represent the only “bank account” they have should they need to make capital improvements, install equipment such as lifts or ramps, or hire a caregiver to live with
them at home. A reverse mortgage may be available to elderly homeowners, which will enable them to draw down approximately 75 percent of the equity in their home on a periodic basis. The loan is not paid back until the homeowner either moves out or dies. At that point, the home is sold and the loan is repaid. These loans can be particularly important to elders who have no immediate family and are trying to remain in the community.

The older the homeowner, the greater the loan amount available. All owners must reside in the home, and must be older than 55. The youngest owner’s age is used as the measuring life. Transferring the primary residence eliminates this option, and also could result in the loss of other benefits, such as real estate tax exemptions. Some elders require care in the home and qualify for Medicaid Global Options, which only provides 25 to 40 hours a week of care. The elder can draw down the equity via a reverse mortgage to pay for the remaining care that is needed.

Preserving the Home by Transferring it to a Trust

Under certain circumstances, older adults may not want to transfer the home to their relatives, but may want to totally relinquish ownership for Medicaid purposes. The property can be transferred to a trust in which the elder and the trustee sign a use and occupancy agreement entitling the elder to reside there if he or she fulfills certain obligations, such as paying rent or expenses in lieu of rent. This arrangement is distinguished from a life estate, and if the trust sells the property, all of the proceeds remain in the trust. If the arrangement meets the requirements for grantor trust treatment under Internal Revenue Code Section 677(a), the capital gains exclusion for sale of the primary residence will be retained, and if the property is not sold during the grantor’s life, the property will be included in the grantor’s estate at death for tax purposes, and will achieve a step-up in basis to the extent allowed by law.

Conclusion

Preservation of the family residence for benefit of the next generation is an important goal for many clients. The real trick is balancing their own financial security against the hopes of their heirs. ☝️

Endnotes

4. N.J.A.C. 10:71-4.1 - 4.6. Higher-income individuals may retain $4,000 under the medically needy Medicaid program.
6. See H.K. v. Division of Medical Assistance and Health Services and Atlantic County Board of Social Services, 184 N.J. 367 (2005) (The date of the gift is based on the deed date, not the recordation date.).
7. N.J.A.C. 10:71-4.7 and 4.10, 42 U.S.C. 1396p(c)(1)(D)(2), and see M.J. v. Division of Medical Assistance and Health Services, HMA 2512-07, final agency decision.
8. N.J.A.C. 10:71-4.4. See A.D. v. Division of Medical Assistance and Health Services, HMA 07269-09, initial agency decision (final agency decision not found.).
10. N.J.A.C. 10:71-4.7(d) and 10:71-4.10(d).
12. N.J.A.C. 10:71-4.10(d), (e) and 42 U.S.C. 1396p(d)(4)(A).

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Client Capacity—Assessment and Advocacy

by Donald D. Vanarelli

Among the more complex ethical issues surrounding the practice of law are the special considerations that must be made when assessing and addressing the needs of a client with questionable capacity. The issue is further complicated by the fact that the standards for determining legal capacity vary, depending upon the transaction to be entered into by the client.

Although an attorney may be precluded from representing a client who lacks capacity, the attorney may nevertheless engage in a meaningful attorney-client relationship with those who have less than full capacity.

**Context-based Capacity Standards**

An individual’s mental capacity is judged based upon the transaction or act the person is undertaking. One commentator explains that legal capacity exists on a spectrum; a person’s capacity may be insufficient to perform what is considered to be a more complex act (such as entering into a contract), but may be sufficient to perform what is considered to be a more simple act (such as making a will).¹

**Contractual Capacity**

The capacity to enter a contract (a retainer agreement is a notable example) exists when “the person in question possesses sufficient mind to understand, in a reasonable manner, the nature, extent, character, and effect of the act or transaction in which he is engaged.” Stated otherwise:

To make a valid contract, each party must be of sufficient mental capacity to appreciate the effect of what he or she is doing, and must also be able to exercise his or her will with reference thereto. There must be a meeting of the minds to effect assent, and there can be no meeting of the minds where either party to the agreement is mentally incapable of understanding the consequences of his or her acts.²

Thus, to find that a person lacked capacity to enter into a contract, “[i]t is not necessary to show that [the] person was incompetent to transact any kind of business, but to invalidate his contract it is sufficient to show that he was mentally incompetent to deal with the particular contract in issue.”³

**Testamentary Capacity**

Adults are generally presumed competent to execute a last will and testament.⁴ Testamentary capacity is evaluated at the time of the execution of a will, and is summarized as follows:

The gauge of testamentary capacity is whether the testator can comprehend the property he is about to dispose of; the natural objects of his bounty; the meaning of the business in which he is engaged; the relation of each of the factors to the others, and the distribution that is made by the will....[a]s a general principle, the law requires only a very low degree of mental capacity for one executing a will....A testator’s misconception of the exact nature or value of his assets will not invalidate a will where there is no evidence of incapacity....[I]t is not ignorance of the kind or amount of property owned by the testatrix which invalidates [a] will, but ignorance resulting from a mental incapacity to comprehend the kind and amount of such property.¹

**Donative Capacity**

New Jersey recognizes the general principle that an adult donor is presumed competent to make a gift. The test of an adult’s capacity to make a gift is that “the donor shall have the ability to understand the nature and effect of the transaction.”⁵ According to *corpus juris secundum*, mental capacity to make a gift is judged by whether an individual has the ability to understand the nature of the transaction, the extent of his or her property, the objects of his or her bounty, and the manner in which the distribution is being made.⁶

In sum, when examining capacity in the context of various types of legal transactions, courts have developed different legal standards for capacity for different legal documents. The tendency in the courts is to find that the more the client is willing to give up or the more complex the act, the more capacity the client must have.⁷
Representing the Client with Diminished Capacity

The New Jersey Rules of Professional Conduct provide a logical starting point for practitioners struggling with issues surrounding a client with less than full capacity. The representation of a client with diminished capacity is governed by R.P.C. 1.14, which provides as follows:

(a) When a client’s capacity to make adequately considered decisions in connection with the representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client’s own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator, or guardian.

But how does the lawyer determine whether the client’s capacity is, in fact, compromised? Unfortunately, R.P.C. 1.14 does not provide standards for determining client capacity (or the varying levels of capacity). Indeed, as one legal treatise concurs:

‘[t]here is a distressing lack of guidance for attorneys dealing with partially incapacitated clients. Yet, it is the attorney’s role, despite lack of any formal medical training, to determine whether a client’s capacity is sufficient to allow him or her to understand and consent to required legal activity.’

Capacity Assessment Tools

Given that lawyers are largely left to their own devices to formulate a method of determining a client’s impairment, there is room for the attorney to “rely on instinct and experience” to make these assessments. However, as one commentator cautions, “in representing elderly clients situations arise with increasing frequency that challenge the attorney’s ability to react on a ‘gut’ instinct alone.”

Rather than relying solely on instinct or experience, the attorney may employ a number of different tests to inform the decision regarding a client’s capacity. One assessment tool, which is popular because of its reliability and ease of use, is the mini mental state exam (MMSE). The MMSE consists of 30 questions, and a score below 24 suggests that cognitive impairment may exist.

Another assessment tool is the Baird B. Brown legal capacity questionnaire, which is said to “combine[] medical and legal principals...to assess the conceptual knowledge required to demonstrate testamentary capacity...[while providing] insight into the client’s mental state.” The client capacity screen is a one-page assessment to assist the lawyer in making a capacity assessment.

Another source of guidance in the assessment of client capacity, provided by the American Bar Association Commission on Law and Aging and the American Psychological Association (ABA-APA), is the 2005 publication titled Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers.

The ABA-APA handbook advocates the use of “markers,” or indicators in the initial assessment of client capacity, which “should not be taken in and of themselves to be proof of diminished capacity,” but instead “may indicate a need for further evaluation of capacity by an independent professional.” The assessment encompasses examination of possible cognitive, emotional, and behavioral signs that may indicate incapacity, and compares the client’s understanding in relation to the legal definition of capacity for the particular transaction in issue.

As the ABA-APA handbook opines, for “many, if not most clients,...clinical consultation or assessment will not be needed to reach a firm conclusion about capacity.” However, the lawyer’s initial assessment of client capacity may be followed by the use of a clinical consultation or assessment, if the lawyer believes it necessary in order to make a capacity determination.

New Jersey courts support a lawyer’s sparing use of referrals for clinical assessment. In Lovett v. Estate of Lovett, a client of advanced age and weakened memory executed a new will that was inconsistent with his longstanding testamentary plan. The legal malpractice claim that followed was based upon the estate planning lawyer’s alleged failure to recommend a psychological evaluation to determine the client’s testamentary capacity, given the client’s age and weakened memory, prior to allowing him to execute the new will.

The court rejected this claim, stating:

The fact that Lovett wanted a simple will in spite of having a substantial estate does not suggest incompetency; nor did his age. The fact that Lovett’s memory was not as strong as it had been, although a factor to be considered, was far from sufficient to warrant [the lawyer’s] refusal to act or to require him to insist that Lovett obtain a psychological exam. Circumstances which would justify a suggestion from a lawyer that a client be psychiatically evaluated as a prerequisite to signing legal documents would be rare. This was not such a circumstance.

Assistance and Advocacy

As a preliminary matter, the lawyer
should routinely counsel a competent client to take steps to protect him or herself in the event of future incapacity, such as through the use of durable powers of attorney, advance directives and healthcare proxies.” However, the attorney is often faced with a client who has not taken these protective steps, and who has reached a level of diminished capacity.

Ethics Opinion 625, Representation of Client Believed to be Incompetent, was issued in response to an attorney’s inquiry regarding the continued representation of a client with questionable capacity in the context of general litigation.

In Opinion 625, the client arrived late to an administrative law hearing and displayed behavior that was “irrational, totally incapable of assisting counsel, agitated and potentially violent.” The client’s husband was attempting to have the client committed for her bizarre and paranoid behavior, and the client had threatened to file ethics charges against her attorney. The client had also rejected a settlement her attorney felt was in her best interests. Based upon these facts, the attorney inquired into whether, and in what manner, he should continue to represent the client.

The New Jersey Advisory Committee on Professional Ethics noted that “the difficulties which inhere in situations such as that presented here are obvious,” and that “several of the lawyer’s basic duties may conflict,” including confidentiality rules and the attorney’s obligation to exhibit candor toward the tribunal. The committee suggested a lawyer may terminate representation if withdrawal “can be accomplished without material adverse effect on the interests of the client,” or if the client insists on a course of action “that the lawyer considers repugnant” or imprudent, or other “good cause for withdrawal” exists.

Cautioning that there can be “no hard, fast or inflexible rules” for resolving situations involving clients with diminished capacity, the committee concluded:

the lawyer must attempt to effectively advise the client of the status of the case unless he soundly believes that she cannot comprehend or that the communication would adversely affect her health or well-being. If either exists, or, as here, she is incapable of effectively assisting in her own defense (based on a firm professional judgment), the appointment of a guardian should be sought. Counsel may continue to represent his client here unless he believes the course of action he is forced to take would be imprudent or if his continued representation would adversely affect his client. He would be required to continue his representation only if his withdrawal could prejudicially affect her."

Advocacy of Client’s Wishes vs. Promoting Client’s ‘Best Interests’

Implicit in entertaining a ‘normal’ relationship with a client with diminished capacity is the struggle between competing views: the lawyer as advocate for the client, on the one hand, and the lawyer promoting what he or she believes to be the ‘best interests’ of the client. However, the generally accepted view is that the lawyer should advocate the client’s wishes, rather than what the lawyer determines to be in the client’s best interests."

The New Jersey Supreme Court addressed whether a “generally incompetent” individual must prove that he or she retains the capacity to choose where to live. During the course of its analysis, in which it emphasized the need to preserve an incapacitated person’s right of self-determination to the extent possible, the M.R. Court examined the actions of M.R.’s court-appointed counsel. In contrasting the role of court-appointed attorney with that of a guardian ad litem, the M.R. Court quoted the Supreme Court Judiciary Surrogates Liaison Committee and Civil Practice Committee guidelines for attorneys, which stated:

[(t)he role of the representative attorney is entirely different from that of a guardian ad litem. The representative attorney is a zealous advocate for the wishes of the client. The guardian ad litem evaluates for himself or herself what is in the best interests of his or her client-ward and then represent[s] the client-ward in accordance with that judgment.

The M.R. decision was founded upon the recognition that “[a]dvocacy that is diluted by excessive concern for the client’s best interests would raise troubling questions for attorneys in an adversarial system.”

Following the M.R. decision, Rule 4:86-4 of the New Jersey Rules of Court was amended to distinguish between the role of guardian ad litem and that of the court-appointed attorney in a guardianship action.

(d) Guardian Ad Litem. At any time prior to entry of judgment, where special circumstances come to the attention of the court by formal motion or otherwise, a guardian ad litem may, in addition to counsel, be appointed to evaluate the best interests of the alleged incapacitated person and to present that evaluation to the court.

Maximizing Client Capacity

In cases in which a client’s capacity may be compromised, the lawyer may utilize a number of practical techniques to maximize that capacity. Physical surroundings may be adapted to maximize the client’s capacity level. For example, because many clients with diminished capacity suffer from difficulties with
sight and hearing, the lawyer may compensate for these impairments by minimizing background noise and glare, directly facing the client, and speaking slowly. In addition, because many older adults function best at certain times of day (generally the morning), the attorney should determine the best time of day for a particular client, and arrange appointments at the older client’s home, where he or she is more comfortable and likely to function more fully.

It is also vital to avoid confusing physical frailty with mental impairment; the ABA-APA handbook advocates the importance of beginning a relationship with a client by presuming capacity, and avoiding a stereotypical attitude toward the older client, as such attitudes can “unconsciously obstruct communication with and perception of the client.”

Endnotes

2. 17A C.J.S. Contracts §141.
7. 38A C.J.S. Gifts §12.
23. Laffitte, E., supra, at 313.
25. Ethics Opinion 625, Representation of Client Believed to be Incompetent, supra, 123 N.J.L.J. 991.

Conclusion

R.P.C. 1.14 is the primary source of guidance for New Jersey attorneys representing clients with diminished capacity. However, as one scholar opines, the model rule, which was adopted as R.P.C. 1.14 in New Jersey, is one of the most well-intended and progressive of the Model Rules....The controversy...lies not in its spirit but rather in its vagueness. The resounding criticism is that lawyers are still plagued with many unanswered practical questions.

It is likely that the reason for the seeming vagueness in R.P.C. 1:14 is that these issues are simply incapable of clear answers, given the infinite range of facts and nuances presented by a given case. The nature of incapacity itself is problematic; one commentator colorfully compares the concept of incapacity to “the lava lamp of the sixties—you can never really pin it down and it changes every time you look at it.”

As the New Jersey Advisory Committee on Professional Ethics correctly observed, “the determination of a lawyer’s responsibilities to a client who suffers from a mental infirmity or disorder is not an easy one.” Perhaps the admittedly vague framework of R.P.C. 1.14 is the best method for allowing the informed attorney to use his or her “firm professional judgment” in practice.22

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Evictions From Long-Term Care

by William P. Isele

Ted

Ted, 89, is retired from the military. Non-ambulatory, incontinent, and suffering from dementia, he was bed bound, and required extensive care from the staff at the South Jersey nursing home where he resided. Ted was not the problem. Yes, he had many needs, but the staff was used to dealing with them. He was compliant with care, and pleasant to the staff. Money was not the problem. Ted had a good pension from the military, and had accumulated significant savings. His only child, Regina, was a highly successful fashion designer, who lived in a penthouse in New York and had plenty of money. Bills were paid promptly. But on her weekly visits, Regina took the nursing home by storm, demanding, insisting, verbally abusing everyone from the housekeeping staff up to and including the administrator. Nothing was ever good enough for her father. Her tirades and abusive conduct resulted in several aides and at least two nurses refusing to care for her father. Two very caring and competent aides had even resigned after receiving tongue-lashings from her. At his wits end, the beleaguered administrator sent Regina a 30-day discharge notice: Take Ted somewhere else; we can no longer meet his needs.

Rita

Rita, 89, had never married, and had no children. She had been one of the first women to hold an executive position with a large Wall Street investment firm, and had devoted her life to her work. She retired in 1992, after 50 years with the firm, and for eight years took cruises, tours and excursions to all parts of the world. By 2001, however, the arthritis in her hands, hips, and knees had become crippling, and she reluctantly accepted the prognosis that she would spend the rest of her life in a wheelchair. She gave up her apartment in the city, and moved to a pleasant and highly recommended nursing home in rural New Jersey. She had thought that her remaining $750,000 savings, plus her pension and Social Security would suffice, but nine years at nearly $100,000 per year, plus the downturn in her beloved stock market in 2008, left her financially embarrassed as 2010 dawned. Not that she hadn’t seen trouble coming; she’d astutely started selling off her weaker stocks in 2005. Lehman Brothers and AIG were the last to go, just before the crash. Unfortunately, she hadn’t been as careful at retaining documentation of her sell-offs of stock as she should have been. Now, with little remaining other than her pension and Social Security income, she has applied for Medicaid. The county board of social services wants more information before it will approve her application; information she simply cannot find. She could not pay the nursing home in full for January and February, and they have given her a 30-day discharge notice. After nine years in the facility, she has nowhere to go, and she is terrified.

Two elderly people, each facing imminent discharge from the facilities that have become their homes. Their different circumstances invoke different legal considerations, different legal provisions, and, therefore, different approaches.

Social Security and Medicare

There is a common misconception that when one is old and in need of long-term care, ‘the government’ will provide. The simple fact of the matter is that Medicare does not pay for long-term care.

Medicare and Social Security are programs of insurance. Employees and employers pay a payroll tax, which functions as an insurance premium. Those of us who have paid into Social Security all our working lives expect the federal government will send us monthly Social Security checks at retirement. This expectation has eroded somewhat in recent years. For our parents, Social Security began at age 65. Now, for those born between 1943 and 1954, ‘full retirement benefits’ can only begin at age 66. Those born in 1960 or later will have to wait until age 67. As fewer and fewer people pay into Social Security, the age at which one can collect full retirement benefits will get later and later.

Medicare is the ‘health insurance’ part of the Social Security, or Old Age Survivors Disability and Health Insurance (OAS-DHI) program. At this writing, workers who have paid into the
Medicare trust fund can receive health benefits from Medicare beginning at age 65. However, in March 2009 Medicare trustees reported that the program has “deteriorated significantly,” and that funds will run out in 2019. Today, more than 41 million Americans are covered by Medicare. The program is funded in part by a 2.9 percent payroll tax. However, payroll taxes will not cover the program’s hospital costs this year, making it necessary to rely on interest earnings from Medicare’s $256 billion trust fund.²

Like many private health insurance programs, Medicare pays for hospitalization (Part A); the services of physicians and other professionals (Part B); and prescription drugs (Part D). No part of Medicare pays for long-term care. Some limited benefits are available for rehabilitation services after a hospitalization, and for this reason, nursing facilities that provide rehabilitation services become Medicare-qualified. Medicare insurance does not cover the type of custodial long-term care needed by individuals like Ted and Rita.

Rights of ‘Private Pay’ Residents

In the opening scenarios, Ted is an example of a private-pay resident. No federal law relates to his circumstances, because the facility receives no federal funds for his care. One must look solely to New Jersey’s long-term care licensing rules.³ Under the rubric “Residents’ Rights,” the rule states that the resident has a right:

To be transferred or discharged only for one or more of the following reasons, with the reason for the transfer or discharge recorded in the resident’s medical record:

i. In an emergency, with notification to the resident’s physician or advanced practice nurse and next of kin or guardian;

ii. For medical reasons or to protect the resident’s welfare or the welfare of others;

iii. To comply with clearly expressed and documented resident choice, or in conformance with the New Jersey Advance Directives for Health Care Act, as specified in N.J.A.C. 8:39-9.6(d); or

iv. For nonpayment of fees, in situations not prohibited by law.

None of the four reasons apply to Ted’s situation as described. The reason stated in the facility’s notice, that it can no longer meet Ted’s needs, is an effort to fit within the second regulatory reason, medical reasons. In fact, there is no medical reason to discharge Ted. The reason is better described as ‘social’ in nature (i.e., the inability of Ted’s daughter and the facility staff to work cooperatively in his best interest).

In a situation such as Ted’s, the facility would do well to reach out to the state ombudsman for the institutionalized elderly, or a private elder mediation service, to facilitate a meeting between the staff and Ted’s daughter, Regina. The facility is rightfully concerned about the loss of trained staff due to Regina’s behavior. Regina may have some legitimate concerns about her father’s care. These issues certainly need to be addressed, but discharge of the father because of the daughter’s disruptive behavior is not permissible.

Rights of the Medicaid Eligible/Medicaid Pending

A governmental program that does pay for long-term care is Medicaid, the joint federal-state program that pays for healthcare services to the poor. To be eligible to receive institutional Medicaid (i.e., payment for nursing home care), one’s total assets may not exceed $2,000 ($4,000 if income exceeds a certain level called medically needy). If a person in a nursing home (known generally as a resident, and to Medicaid as a beneficiary) cannot pay privately, and is not eligible under Medicaid rules to have his or her stay paid for by Medicaid, it may seem as though the nursing home may discharge the resident under the fourth reason indicated above, for nonpayment, in situations not prohibited by law. One must ask, however, in what situations would discharge be prohibited by law?

Federal Medicaid Provisions

The answer to that question lies in the contract between Medicaid and the nursing facility, which allows the facility to be reimbursed by Medicaid—the Medicaid provider agreement.

As might be expected, the Medicaid provider agreement requires the provider-facility to comply with all state and federal Medicaid laws, rules, and regulations. Under the federal Medicaid regulations,⁴ in order for a facility to participate in the Medicaid program:

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(i) The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.
There are documentation and notice requirements that are triggered by a decision to discharge, but essentially these six reasons are the only permissible grounds for discharging a nursing home resident who is Medicaid-eligible. The fifth reason seems germane to this issue of non-payment, but again, is subject to conditions. How does a nursing home resident “have [his or her stay at a facility] paid [for] under Medicare or Medicaid”?

The answer cannot be found in the federal regulations. Rather, as noted above, Medicaid is a joint federal-state program. The process by which a person’s stay in a nursing facility is reimbursed by Medicaid is defined in applicable state rules.

State Medicaid Rules

This rule addresses the issue of involuntary discharge in greater detail and specificity than does the federal regulation. The language of the entire regulation is protective of Medicaid recipients, and deserves careful reading. One must begin, however, with the definition of “Medicaid beneficiary”:

A Medicaid beneficiary is a Medicaid eligible individual residing in a N[ursing] F[acility] which has a Medicaid provider agreement. This includes... an individual who had entered the facility as non-Medicaid and is awaiting resolution of Medicaid eligibility.

Consequently, a person who has applied for and is currently awaiting resolution of his or her Medicaid eligibility, is considered a beneficiary, entitled to all the other protections and procedures found in the rest of this rule. The rest of the rule, and some subsequent sections, lay out very specific procedures that must be followed if a Medicaid beneficiary is to be discharged or transferred from the facility.

No Right to Evict

Under the federal regulation, a nursing facility may believe that it has the ‘right’ to transfer a person who is awaiting Medicaid approval out of the facility, because he or she “has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicaid) his/her stay at the facility.” But neither the federal regulations nor the state rules create a ‘right’ to evict. Rather, the regulations limit and restrict the circumstances under which a nursing facility can ever evict a resident. Even those residents who fall into one of the threshold exceptions listed in the federal and state rules are entitled to additional rights and procedures under the state Medicaid rules. These provisions are designed to protect the often elderly, infirm, and disabled persons who have applied for, and are awaiting resolution of Medicaid eligibility. A person who has applied for, and is actively pursuing Medicaid eligibility, like Rita in our scenario, cannot be said to have failed to act.

Federal-State Construction

It may be instructive to compare the general language of the federal regulation with the more specific language of the state Medicaid rule. The former prohibits discharge of a resident unless “the resident has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) a stay at the facility.” As indicated above, it is unclear what the resident must do in order to “have paid under Medicaid or Medicare.”

The state rule clarifies the federal regulation, in that it prohibits discharge of a resident unless “the resident has failed, after reasonable and appropriate notice, to reimburse the N[ursing] F[acility] for a stay in the facility from his/her available income as reported on the PA-3L.” Here, clearly stated, is the resident’s responsibility.

The PA-3L form, titled “Statement of Income Available for Medicaid Payment,” is completed by the county board of social services when a resident’s Medicaid application has been approved. It summarizes the resident’s complete financial information. But the PA-3L is completed only upon approval of a Medicaid application. If a person’s application is still pending, no PA-3L would yet have been completed.

Some nursing home administrators may feel the applicant should pay at the private-pay rate, until Medicaid is approved. Logically, however, this is not always possible, because the applicant, in order to be Medicaid eligible, cannot have resources in excess of $2,000. Many applicants have less than that. While most elder care attorneys recommend beginning the Medicaid application process at least six months before a resident’s funds are likely to be spent down, sudden illness or hospitalization, or a downturn in the economy, can drastically shorten the period for those who follow that advice. Many Medicaid applicants cannot afford to seek a lawyer’s advice, or seek it too late for it to be helpful. Nevertheless, such an applicant is not refusing to pay, but is by definition unable to pay, while awaiting resolution of Medicaid eligibility.

To emphasize the fact that a facility has no ‘right’ to discharge or transfer a Medicaid beneficiary (as defined above), the state Medicaid rule goes on to state:

In any determination as to whether a transfer is authorized by this rule, the burden of proof, by a preponderance of the evidence, shall rest with the party requesting the transfer, who shall be required to appear at a hearing if one is requested and scheduled.

Thus, counsel representing a person who, although having applied for Medicaid is being threatened with discharge for nonpayment, should request a fair hearing, in writing.

There Can Be No Involuntary Discharge Without a Discharge Plan

Even when a facility has lawful
grounds for involuntary discharge, it must develop an appropriate discharge plan. The facility must designate a location to which it intends to discharge the beneficiary, and must state how the beneficiary’s health and social needs are to be met. Lest there be any doubt, state licensure rules mandate that:

Discharge plans, for those residents considered to be likely candidates for discharge into the community or a less intensive care setting, shall be developed by the interdisciplinary team prior to discharge and shall reflect physician’s orders, and communication with the resident and the resident’s family.14

The rule describes some of the factors that must be taken into account, including, but not limited to, the effect of relocation trauma on the beneficiary, the proximity of the proposed placement to family and friends, and the availability of necessary medical and social services. Thus, the rule presumes that any discharge must be thoroughly planned, and focused on the needs of the beneficiary.

The circumstances and medical needs of many residents are such that no acceptable plan for their discharge to the community could be written, even assuming that a location for discharge could be identified.

State Medicaid rules also set forth very detailed and specific considerations and procedures for the relocation of a resident.15 Prior notice of a discharge must be submitted to the Department of Health and Senior Service’s Long-Term Care Field Office (LTCFO), with documentation of the reasons for discharge. Only after the LTCFO determines a transfer is appropriate can the facility give a 30-day written notice to the beneficiary and the beneficiary’s representative (with copies to the LTCFO and the Office of the Ombudsman for the Institutionalized Elderly). That notice must advise the beneficiary of his or her right to a hearing. Should the hearing confirm the appropriateness of the discharge, counseling and a review of the new location by the LTCFO is required.

Finally, no owner, administrator or employee of a nursing facility may attempt to have beneficiaries seek relocation by harassment or threats. Such actions could result in termination of the Medicaid provider agreement.

Conclusion

Not everyone can count on ‘the government’ to pay for their care when they are aged and ill. Medicaid beneficiaries, however, including those who have applied for Medicaid and are awaiting resolution of their Medicaid eligibility, have significant rights. Nursing facilities do not have a ‘right’ to evict these individuals, and must carefully follow procedures detailed in Department of Health and Senior Services regulations to seek approval for discharge in appropriate cases.

Endnotes

4. 42 C.F.R. §483.12(a)(2).
5. N.J.A.C. 8:85-1.10.
6. N.J.A.C. 8:85-1.10(d).
8. 42 C.F.R. §483.12(a)(2)(v) and N.J.A.C. 8:85-1.10(e).
9. N.J.A.C. 8:85-1.10 (f), (g) and (h).
11. N.J.A.C. 8:85-1.10(e)(3).
12. N.J.A.C. 8:85-1.10(e)(3).
13. N.J.A.C. 8:85-1.10 (f).
15. N.J.A.C. 8:85-1.10(g) and (h).

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Special needs settlement planning combines traditional government benefits planning with settlement-related issues as varied as identifying government benefits programs; determining and compromising Medicare, Medicaid and other liens; advising the personal injury attorney and the client regarding settlement vehicles in the context of disability planning; preparing and administering special needs trusts (SNTs); and creating Medicare set-aside arrangements (MSAs).

The special needs attorney plays a distinctive and important role in personal injury settlement planning. While the personal injury attorney focuses on the litigation issues that will obtain the best settlement for the plaintiff, the special needs attorney focuses on issues unique to individuals with disabilities. As a result, the earlier the special needs attorney enters a case, the greater the benefit to the plaintiff. The personal injury attorney benefits from early intervention by the special needs attorney, since the services provided by the special needs attorney allow the personal injury attorney to concentrate on the litigation and settlement issues without the distraction of disability issues that are typically not his or her area of expertise.

The failure of a personal injury attorney to involve the special needs attorney early in the case may cost the injured party a valuable planning opportunity. For example, the personal injury attorney may not appreciate the fact that a special needs trust cannot be established for individuals over the age of 65, or that New Jersey does not allow people over the age of 65 to place assets in a pooled trust. The earlier a special needs attorney becomes involved, the more likely the injured party will receive the best possible advice.

Ascertain the Needs of the Plaintiff with Disabilities

An injured person is in immediate need of medical care. The person may lose his or her job, and subsequently group health insurance. A special needs attorney can assist in determining what government benefits programs are available to assist the person until the matter is ultimately settled, and thereafter. There are a number of government benefits programs to consider for a person with disabilities. While an in-depth examination of these programs is beyond the scope of this article, the plaintiff’s eligibility for Supplemental Security Income (SSI), Medicaid, Social Security Disability (SSD), Medicare and federally assisted housing should be considered. Preparing a special needs trust may enable the injured party to qualify for means-tested government benefits during the pendency of the lawsuit.

The special needs attorney should gather information about the injured party as soon as possible. It is important to know the date and nature of the injuries; the long-term prognosis; the public benefits the injured party already receives; costs advanced by family members, if any; and other creditors such as recipients of court-ordered child or spousal support. Also significant is a description of the injured party’s assets, the life care plan, estate planning documents, medical information and guardianship/conservatorship appointments.

A life care plan is designed to assess the individual’s current and future needs, and the associated costs. Life care plans recommend appropriate medical equipment, services and treatment; project costs for the recommendations; and consider the current support system of the individual and alternatives in the event the current support system becomes unavailable.

Public Assistance Programs

The special needs attorney assists the personal injury attorney in determining the public benefits programs for which the injured party is or may become eligible, and the issues presented by those programs, such as:

**SSI.** A means-tested, federal welfare program providing the recipient with a cash benefit for food and shelter. SSI benefits are reduced dollar-for-dollar for “countable income.” SSI
recipients may not have more than $2,000 of countable resources, including assets of any trust funded with the property of an SSI recipient, unless the trust was created pursuant to 42 U.S.C.A. § 1396p(d)(4)(A). A special needs trust for a tort victim should be structured to avoid payment of trust assets directly to the recipient, so SSI benefits are not reduced or lost, and so trust assets in excess of $2,000 remain ‘unavailable’ to the recipient.

**Medicaid.** A means-tested federal and state program covering a broad spectrum of medical services without deductibles, co-payments or coverage limits. Medicaid has stringent financial eligibility requirements, including income and resource limitations, as well as penalties for the transfer of assets. New Jersey is an SSI state, meaning all SSI recipients are automatically eligible for Medicaid.

**SSD.** A federal cash benefit program for the benefit of a person with disabilities (as defined under the Social Security Act) administered by the Social Security Administration. SSD is an insurance program based on the Social Security earning records of the SSD recipient that is not means-tested. If a child becomes disabled prior to attaining the age of 22, eligibility is based on the earnings record of a retired or deceased parent.

**Medicare.** A federal medical insurance program established under the Social Security Act and 42 U.S.C.A. §1395 that is not means-tested. To be eligible for Medicare, a person must be: 1) age 65 or older and either eligible for Social Security or Railroad Retirement benefits or the spouse or surviving spouse of a person who is eligible for Social Security or Railroad Retirement benefits; 2) age 65 or older and divorced from a person who is eligible for Social Security or Railroad Retirement benefits, where the marriage lasted at least 10 years and the person did not remarry; 3) under age 65 and, with few exceptions, receiving Social Security Disability benefits for 25 months. 4

**Federally Assisted Housing.** These are programs that provide subsidized housing, including Section 8 rental assistance for low-income families. 5

**Determine and Compromise Claims and Liens**

Settling a personal injury case can take years from the time the injury occurs. During that time, if the injured party accesses benefits such as Medicaid, Medicare, or Employee Retirement Income Security Act (ERISA) medical insurance, there are liens that must be settled prior to settlement of the personal injury case.

**The Medicare Lien**

The Medicare Secondary Payer Program (MSP) provides that Medicare is a secondary payer for any medical services for which payments have been made, or can reasonably be expected to be made under worker’s compensation or other insurance, including automobile, health or liability policies. MSP creates a statutory lien for payments made under the Medicare Secondary Payer Act. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 expanded Medicare’s recovery authority, allowing the government double damages from parties who settle cases without satisfying the Medicare lien. This provision places a great responsibility on attorneys to assure they are compliant. Medicare Part D and Medicare Advantage have a separate right of recovery. 10

To the extent Medicare makes a payment in a third-party liability case, the payment is conditional and must be repaid when the matter is settled. Medicare’s right of recovery has priority over any subrogated right, and also has priority over Medicaid. Medicare is not bound by a settlement made between the beneficiary and the responsible party. Medicare may pursue its own claim against the liability insurer. If the liability insurer does not properly pay Medicare, Medicare has the right to take legal action against the insurer and to collect double damages. 11

Determining the correct amount of the Medicare claim is an important part of the attorney’s role. Centers for Medicare and Medicaid Services (CMS) can provide a conditional payment summary on request. Medicare considers all monies recovered to be related to medical expenses, regardless of how they are characterized. Medicare will recognize allocation of liability payments for non-medical loss only when payment is based upon a court order that specifically designates amounts that are not related to medical expenses, such as amounts for pain and suffering.

Medicare recognizes a proportionate share of the necessary procurement costs (i.e., court costs and attorney fees incurred in obtaining a settlement) as a reduction to Medicare’s repayment. 12

Plaintiff’s counsel must notify Medicare of any possible settlement prior to final settlement or adjudication of the case on its merits. Medicare will then stipulate to its claim, preventing additional subsequent charges. A Medicare claim may be asserted even against the estate of a deceased plaintiff.

The amount of the Medicare lien may be appealed in writing. The three levels of appeal are waiver, partial waiver and compromise. A waiver can be requested of a Medicare contractor after settlement is reached and Medicare has set a final claim amount based on financial hardship. Alternatively, only CMS has authority to compromise a Medicare lien. A request for compromise may be made prior to or after settlement. A partial waiver based on facts and circumstances may be granted against a specific entity. If the initial request for waiver, compromise or partial waiver is denied, an appeal for reconsideration may be made. 13
The Medicaid Lien

Federal law requires each state Medicaid program to ascertain the legal liability of third parties to reimburse for medical assistance provided by the state, and to recover from third parties the cost of medical assistance provided. In New Jersey, the attorney general is required to enforce rights against third parties for recovery of medical assistance payments. The Medicaid recipient, or his or her guardian, executor, administrator or other appropriate representative who brings an action for damages against a third party, must provide written notice to the appropriate Medicaid agency. As a condition of eligibility for medical assistance, a Medicaid recipient assigns to the state any rights to payment for medical care from a third party.15

The United States Supreme Court has held that federal laws requiring a Medicaid recipient to assign payments from third parties only extended to medical care, and did not allow state Medicaid agencies to collect on amounts attributable to future expenses, permanent injury and lost earnings.16

Medicaid may waive or compromise the enforcement of a lien in hardship situations. In some states, however, hardship waivers are not available. The New Jersey Appellate Division found that states have a duty of repayment to the federal government of monies expended by the federal government, even if the state compromises a lien, and therefore the state of New Jersey can refuse to compromise the lien.17

Failure to notify the appropriate agencies when a lien may exist may result in the attorney’s liability for satisfaction of the lien. An attorney was held liable for satisfaction of a lien where he or she elected to structure an entire settlement, other than attorney’s fees, thus failing to protect Medicaid’s lien.18

Employee Retirement Income Security Act (ERISA) Liens

ERISA preempts state law in the area of self-funded employee benefit plans.19 There are two important exceptions known as the savings clause and the deemer clause. The savings clause states that ERISA does not exempt any person from any state law regulating insurance banking or securities.20 The deemer clause states that an employee benefit plan or trust under such a plan shall not be deemed an insurance company or other insurer, bank, trust company, or investment company for purposes of any state law regulating insurance companies, insurance contracts, banks, trust companies or investment companies.21 It establishes as an area of exclusive federal concern the subject of every state law that “relate[s] to” an employee benefit plan governed by ERISA.

The saving clause returns to the states the power to enforce those state laws that “regulate insurance,” except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be “deemed” to be an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws “purporting to regulate” insurance companies or insurance contracts.22

As a result, a self-insured employee benefit plan has federal preemption under ERISA and recovery is governed by the terms of ERISA, whereas an employee benefit plan governed by an insurance company is subject to state law with regard to any right of recovery. ERISA provides that a civil action may be brought by a plan fiduciary to obtain appropriate equitable relief to enforce any provisions of ERISA or the terms of the plan.23

In Sebeboff v. Mid Atlantic Med. Servs., Inc.,24 the seminal case on ERISA liens, the fiduciary of an ERISA health insurance plan sued the beneficiaries to collect medical expenses paid by the plan on their behalf. The plan contained an “Acts of Third Parties” provision requiring beneficiaries to reimburse the fiduciary for all third-party recoveries. The beneficiaries were injured in an auto accident, and the plan paid their medical expenses. The fiduciary sought reimbursement of those expenses upon the settlement of the beneficiaries’ tort case. The Court held the fiduciary’s action to enforce the acts of third parties provision was authorized as equitable relief under Section 502(a)(3) of ERISA.

To determine whether there is an ERISA lien, the special needs attorney must first determine whether the plan is self-funded, and therefore governed by ERISA and not state law. If it is an ERISA plan, the plan itself must be reviewed to determine whether its language provides a right of recovery. In addition to looking to the language of the plan, there are other possible defenses to an ERISA claim: the “make whole” doctrine; equitable contract defenses; specific fund doctrine; and application of Ahlborn.25

The make whole doctrine, whereby an injured person should be fully compensated for injuries prior to reimbursement for medical expenses, is the default law in most states, and is part of federal common law. Specific language in a plan can negate the doctrine; however, standard subrogation language does not negate it.26 Cases involving the make whole doctrine have produced mixed results.27

Enforcement of an ERISA lien is an equitable action arising out of contract law. As a result, equitable defenses may be effective counters to an ERISA claim.28 Among these are the defenses of “equity will not aid in the enforcement of forfeiture” and “unclean hands.”29

The specific fund doctrine was the principal at work in Sebeboff. Settlement funds in Sebeboff were set aside during the resolution of the lien. The Court held that the lien was only enforceable against a specifically identified fund. The plan language limited its right of recovery to the amount paid for care associated with the injury, not the
entire settlement. As a result, the language of the ERISA plan must be analyzed to determine if it identifies a specific fund or if it does not limit the plan’s recovery to the amount paid for care associated with the injury. If not, the lien is not enforceable.

Medicare Set-aside Trusts

While resolving Medicare liens addresses medical expenses paid by Medicare prior to the settlement of a case, Medicare set-asides address medical expenses that will be incurred after the settlement of a case. A portion of the settlement is set aside in a trust created for this purpose. The Medicare Secondary Payer Program (MSP) provides that Medicare is a secondary payer for any medical services for which payments have been made, or can reasonably be expected to be made. Payment of future medical expenses is covered under the MSP.

Worker’s compensation is a program that compensates workers for injuries sustained on the job. If an injured worker is eligible for Medicare, Medicare is a secondary payer of medical expenses to worker’s compensation. Most state worker’s compensation programs provide for final settlements to close a claim, ending the employer/insurer’s financial obligation. Once a final settlement is reached, the injured worker cannot look to the employer/insurer for payment of medical expenses associated with the injury.

Medicare has an interest in a lump-sum settlement to the extent that the funds are intended to pay future medical expenses. To prevent such a settlement from shifting responsibility for payment of future medical costs from the primary payer to Medicare, Medicare requires a portion of the settlement to be set aside for payment of future medical benefits that Medicare would otherwise pay.29 The amount of the set-aside is determined on a case-by-case basis, and should be reviewed by CMS. Once the CMS determined set-aside amount is exhausted and accurately accounted for to CMS, Medicare becomes the primary payer for future Medicare-covered expenses.30

Worker’s compensation commutation cases are settlement awards intended to compensate individuals for future medical expenses resulting from a work-related injury. Compromise settlements, on the other hand, are deemed to be a worker’s compensation payment for current or past medical expenses. Medicare set-asides are only required in commutation cases.

Third-party Liability Cases

All insurers, third-party health plans, self-insured plans and self-administered plans are required to identify situations where the plan is or has been a primary plan to Medicare. Failure to comply results in a penalty of $1,000 for each day of noncompliance for each individual for whom the information should have been submitted.31 Medicare does not require set-asides for third-party liability cases at this time, mainly because CMS does not review liability settlements as it does worker’s compensation settlements. Therefore, there is no mechanism in place to calculate a set-aside amount to protect Medicare’s interests.

Nevertheless, plaintiffs’ attorneys may wish to calculate a set-aside amount using the rules CMS imposes on worker’s compensation cases. Alternatively, there are companies that specialize in determining the amount of Medicare set-asides and establishing Medicare set-aside trusts.

Structured Settlement Planning

A structured settlement commonly involves the purchase, by the defendant’s insurance carrier, of an annuity calculated to pay certain sums at regularly scheduled intervals in the future. Insurance carriers representing defendants in a personal injury case often favor structured settlements because they can settle the case for less money up front than the actual value of the case. Insurance companies, however, often are unwilling to disclose the amount that will be paid to purchase the annuity. This makes it difficult for the plaintiff’s lawyer to evaluate the merits of the settlement offer.

Structured settlements are intended to provide a secure and fixed stream of recurring payments to a claimant over a long period of time. They avoid dissipation of lump sums by injured parties who may then be left without means of support. Strong public policy in favor of deterring claimants from squandering their settlements or awards has led to favorable tax rules for structured settlements.

Structured settlement proceeds are not subject to income tax. The proceeds, however, can be subject to federal estate tax if the settlement is structured with guaranteed payments so the person with disabilities would receive payments for life and another person would receive payments upon the death of the disabled person. Under those circumstances, the present value of the payments to be received by the other person would be included in the deceased person’s estate.

Structured settlement annuities can be combined with lump-sum payments to meet the specific needs of the injured individual. For example, lump-sum payments can be used to pay medical bills, rehabilitation costs and debts of the injured party.

Settlements can be structured without the purchase of an annuity. The plaintiff can settle the matter for a lump-sum and future payments, and assign a certain amount of the settlement proceeds to a structured settlement trust. The trustee invests the proceeds to maximize asset growth and income, and makes periodic payments to the injured party.
Structured Settlement Planning with Special Needs Trusts

Payments from a structured settlement can be made to a special needs trust. A special needs trust enables the individual with disabilities to retain existing means-tested public benefits, such as SSI and Medicaid, or to financially qualify for such benefits while having funds available to supplement the individual’s needs that are not covered by government programs. The trust funds can be used for a myriad of purposes, such as additional support services at home, vacations, companions, vehicles and a residence. If a special needs trust is created, the amount in the trust paid back to Medicaid will be deductible for federal estate tax purposes as a claim against the estate.

A structured settlement may be advantageous to the plaintiff because of the availability of large sums of money to the trustee of a special needs trust. Structured settlement payments often provide a fixed stream of income, and therefore, they usually will not be subject to unfavorable economic conditions, such as recessions or inflation.

One of the disadvantages of structured settlements, however, is the inability of the injured party to change the amount received or the schedule of payments. When circumstances change and the injured party needs a lump sum of money (to purchase a house, for example) the injured party cannot simply give the annuity back to the life insurance company for a lump sum.

Similarly, the injured party is unable to unilaterally change the payee of the structured settlement. Yet often there is a need to make such a change when it is subsequently determined that the payments should be deposited into a special needs trust so the injured person can receive public benefits.

If structured settlement payments are going to be placed into a special needs trust, the defendant, or his or her assignee, should purchase the structured settlement to avoid constructive receipt by the plaintiff or the special needs trust, and to avoid the loss of the benefit of tax-free interest.

The trustee of the special needs trust should be named as the recipient of the structured settlement payments. If the individual with disabilities is named as the recipient, the payments can disqualify the disabled person from receiving means-tested benefits, such as SSI and Medicaid. A judgment involving both a structured settlement and a special needs trust should direct the periodic payments from a structured settlement to ‘pour over’ into the special needs trust.

Qualified Settlement Funds

Section 468B of the Internal Revenue Code authorizes the establishment of qualified settlement funds. A qualified settlement fund (QSF) permits a plaintiff to set up a structured settlement without participation by the defendant, so the plaintiff can receive certain tax advantages of these settlements with provisions that best meet his or her needs. QSFs typically are used to settle class action litigation, but they also can be used by plaintiffs with individual claims. QSFs provide defendants with an immediate tax deduction, as well as a full release.

After the settlement or trial proceeds have been deposited into the QSF, the funds can be turned over to the plaintiff, paid into a special needs or other trust, or used to buy a structured-settlement annuity that would provide the same tax advantages to the plaintiff as a structured settlement purchased by a defendant insurer.

Guardianships/Conservatorships

When the injured party is mentally incapacitated or a minor, it may be necessary to have a guardian or conservator appointed to prosecute and settle the personal injury litigation, or to provide judicial oversight of the settlement or litigation proceeds. The special needs attorney can file a guardianship or conservatorship proceeding under Rule 4:86 and assist the personal injury attorney in obtaining court approval for the settlement and the establishment of a special needs trust.

Determining the Appropriate Fiduciaries

The assistance of the special needs attorney is valuable in identifying an appropriate guardian and trustee. That attorney can recommend corporate fiduciaries, when appropriate, and counsel the injured party or family members with respect to the qualifications that should be considered in choosing fiduciaries. Family members may not be the best choice as trustee.

A fiduciary must exercise a high degree of care when dealing with and managing the property of a ward or beneficiary. A fiduciary’s interest cannot conflict with the duty of loyalty.32 This high standard is quite rigid. A trustee is a fiduciary, and, among other things, a trustee must follow the terms of the trust regarding how it should be managed.

Guardians and trustees must keep accurate records. The fiduciary may be required to act in accordance with the state’s Prudent Investor Act or as a reasonably prudent investor pursuant to the common law of a state that has not enacted the Prudent Investor Act. Some states require trustees of third-party trusts to render accountings on a regular basis (such as once a year), and the trust itself may contain provisions regarding how often the trustee must provide such an accounting.

New Jersey regulations mandate additional responsibilities for special needs trustees, including, inter alia: 1) periodic accountings of all expenditures
be submitted to the appropriate public benefits agency; 2) advance notice to the state of any expenditure in excess of $5,000, and of any amount that would substantially deplete the principal of the trust; and 3) reporting additions to trust corpus to the appropriate public benefits agency.\footnote{Shirley B. Whitenack is a partner with Schenck, Price, Smith & King, LLP in Florham Park and Paramus. She is a fellow and director of the National Academy of Elder Law Attorneys, a member of its invitation-only Council of Advanced Practitioners, a member of the invitation-only Special Needs Alliance, and a former chair of the NJSBA’s Elder & Disability Law Section. Regina M. Spielberg is a partner with the firm, concentrating her practice in elder and disability law, estate and trust planning and administration. She is chair of the Real Property, Trust and Estate Law Section of the NJSBA and is certified as an elder law attorney by the ABA-accredited National Elder Law Foundation.}

Resource and Income Limitations

A trustee of a special needs trust must understand the public benefits programs that may be available to the beneficiary. A special needs trust is intended to preserve eligibility for means-tested government benefits programs such as SSI and Medicaid. Such programs limit the amount of resources the beneficiary can own and the amount of income he or she can receive. The beneficiary’s receipt of income or the provision by the trust funds of food or shelter can adversely affect eligibility for such programs. Accordingly, the trustee must administer a special needs trust with constant consideration of those resource and income limitations. \footnote{Id}

Endnotes

1. 20 C.F.R. § 416.1216(a)-(b).
4. 42 C.F.R. § 406.5.
7. 42 U.S.C. 1395y(b).
12. 42 C.F.R. § 411.37(a).
14. 42 U.S.C. § 1396(a)(25)(A) and (B).
27. Id
33. N.J.A.C. 10:71-4.11(g)
The Use of Trusts in Divorce
When Planning for the Disabled Spouse or Child

by Susan L. Goldring

As divorcing clients age and more children seem to have some form of serious disability, the family law practitioner faces an entire new area of concern. How does the attorney do the best for the client? To what extent does the attorney for the disabled client need to consider the needs of the client in the context of the rest of the family? And what is the attorney’s obligation to disabled children who do not have independent representation?

The purpose of this article is to acquaint the family law practitioner with the basic concepts regarding disability and trust law and their interplay with matrimonial law. Some of the trust concepts discussed in this article can be used successfully in non-disability situations as well. The family lawyer will benefit from a basic understanding of disability concerns and the nature of available trust solutions.

In a divorce, the starting point for settlement agreements requires consideration of the equitable distribution factors spelled out in N.J.S.A. 2A:34-23.1; the alimony factors in N.J.S.A. 2A:34-23 a.; and the child support guidelines and factors, if applicable, in N.J.S.A. 2A:34-23 b. In looking at these factors, the practitioner must use a disability lens. Is the disabled spouse or child currently receiving any supportive services, and if so, how are the services being financed? What will be the future need for such services, and how will these services be provided? Is there any disability insurance as a source of income?

Special Needs Trusts

The New Jersey statutes specifically allow for trusts to be used to protect support obligations to children and spouses. Federal law permits a disabled person under the age of 65 to fund a trust to meet the special or supplemental needs not met by programs such as Supplemental Security Income (SSI) and Medicaid (commonly referred to as a d4A trust or special needs trust (SNT)). The SNT must be drafted to meet the statutory and regulatory requirements, and must include a payback provision upon the death of the beneficiary to Medicaid and certain other government programs.

While trusts are not commonly used in divorce proceedings, their creative use in disability cases can provide solutions for the entire family.

A special needs trust contains the assets, and sometimes the income, of the disabled person. The trust must be for the sole benefit of the disabled person. It can be created by the parent, grandparent, or legal guardian of the disabled person, or by a court. In the divorce situation it is usually created by the court and funded with the disabled spouse’s equitable distribution and support, if paid.

While the SNT cannot qualify as such unless the disabled person meets the level of disability required by Social Security (whether or not he or she is receiving benefits), it may be useful to create the trust at the time of the divorce but not fund it until later, to avoid further court proceedings.

The question of when to fund the trust and with what, largely depends on the facts of the case, but funding must be done before the beneficiary reaches the age of 65. The only general rule is to avoid funding the trust with retirement funds, as this can create a number of tax problems. The trust can even receive periodic payments in lieu of alimony.

The SNT cannot pay the beneficiary for food or shelter, or give the beneficiary regular cash payments if the beneficiary is receiving SSI or Medicaid. These cash payments will be considered income to the beneficiary and, depending on the amount, may disqualify the beneficiary for SSI and Medicaid benefits. If the SNT pays the vendor directly for food and shelter, the payments are considered ‘in-kind’ and result in an approximate maximum one-third reduction in the SSI payment to the beneficiary.

The SNT can pay for medical expenses not covered by Medicare, Medicaid or any other insurance, such as eye care, dental care, etc. It can also pay for insurance premiums, home health aides not otherwise covered, and transportation.
trust can be used for recreational activities such as travel and entertainment, including paying for a companion if necessary. It can pay for quality of life items such as a computer, specially equipped telephone, television and other electronics.

The SNT can also be structured to function whether or not a disabled spouse is receiving benefits that require income and asset limitations. This may be desirable when the disabled spouse is in the early stages of disability, or the nature of the disability is episodic, perhaps requiring periods of hospitalization.

Before considering using a trust, some basic questions need to be answered. The needs of the disabled spouse, as well as those of the rest of the family, particularly the dependent children, need to be addressed. Are there ways to meet the needs of the disabled spouse without driving the rest of the family into poverty? Is there insurance to offset some or all of the disabled spouse’s expenses?

If a working spouse becomes disabled, he or she may qualify for Social Security Disability, depending on his or her work history. Most people need 40 work credits, 20 of which were earned in the 10 years prior to cessation of employment. An individual can earn up to four credits a year based on the earning level in each quarter. For Social Security purposes, disability means Social Security has determined that: a) a person cannot do work that he or she did before; b) the person cannot adjust to other work because of the medical condition(s); and c) the disability has lasted or is expected to last for at least one year, or to result in death. If the spouse qualifies, then the children under age 18 (19 if the child hasn’t finished high school) can also receive benefits, as can a healthy dependent spouse and a disabled child, under certain circumstances.

**Equitable Distribution is Not Necessarily Equal**

While the general starting point for equitable distribution may be an equal division of most marital property, the fact that New Jersey is not a community property state and has established factors for determining equitable distribution can permit deviation from the norm. In drafting a trust, consider the amount of funds available to the disabled spouse from such sources as Social Security Disability, private disability insurance and long-term care insurance, as well as the current level of care and how the care needs will change over time.

The attorney and disabled spouse must consider whether retention of income or assets by the disabled spouse will interfere with the spouse’s ability to obtain assistance from such programs as Medicaid. Furthermore, assuming that the disabled spouse can qualify for public assistance, are there needs of that spouse that cannot be met by public assistance and need to be met in some other way?

A disabled spouse may also have access to disability insurance through his or her employment, the spouse’s employment, or through a private policy. The disabled spouse may have long-term care insurance, especially if it is offered through employment. These policy benefits will affect the calculations.

A disabled spouse who is eligible for Social Security Disability payments will qualify for Medicare two years from the date of onset of the disability. For that two-year period, provisions must be made for the continuation of existing medical insurance through COBRA or some other means, including provision for the payment of the insurance premiums. When the disabled spouse becomes eligible for Medicare, he or she will start paying for Medicare Part B and D (prescription drug) premiums, as well as a Medigap policy to handle some of the uncovered medical expenses, deductibles, and co-pays not covered by Medicare Parts A and B.

These expenses need to be factored in when setting a budget for the disabled spouse. If the disabled spouse is eligible for Medicaid, some or all of the medical insurance premiums may be paid by Medicaid.

In looking at the support and equitable distribution to the disabled spouse, a critical factor may be lifestyle. If the disability is such that no matter what the disabled spouse receives as support and equitable distribution, his or her quality of life cannot be maintained, it may be reasonable to leave most or all of the income and assets to the healthy spouse.

In making this decision, the parties should consider the healthy spouse’s needs and earnings, as well as whether the healthy spouse has the responsibility of raising, caring for and educating children. The support needs of a disabled spouse living in the community may not differ from those of a healthy spouse. On the other hand, support needs may differ due to an inability to maintain significant gainful employment, or the inability to manage one’s own finances and make appropriate decisions, as in the case of mental illness.

Remember that the disabled spouse has a legal obligation to help support any unemancipated children, regardless of the spouse’s disability. This obligation may best be met by a disproportionate allocation of assets to the healthy spouse, or a reduction or elimination of spousal support. Some form of trust to hold the disabled spouse’s funds for the support of unemancipated children may be appropriate in the right case.

While Social Security Disability and Medicare are entitlements based on work history, Medicaid and SSI are poverty programs requiring minimal assets and income. The permissible assets and income limits vary with the type of program, and are usually not of
concern to the family law practitioner, except as applied to children or institutionalized spouses. In New Jersey, all SSI beneficiaries are entitled to receive Medicaid. Some people who are ineligible for SSI may still qualify for Medicaid, especially if they live in a setting such as a nursing home or assisted living facility.

In the case of a disabled child, the important thing to know is that the income of the parents is deemed by Medicaid and Social Security to belong to the child until he or she reaches the age of 18, generally rendering the child ineligible for these programs. Therefore, consideration of Medicaid and SSI for a disabled child becomes important only after the child reaches the age of 18.

**Supporting a Disabled Child**

Providing for a disabled child raises distinct questions. Generally, in the case of a minor child, the local school system is providing services, possibly with some assistance from the Division of the Developmental Disabilities (DDD) in the Department of Human Services. Children age out of the system at 21.

Will the school services be sufficient to bring the child to a point of independence by age 21, or will the child always need the assistance of the parents? If parental support will be required, what are the options for funding the support? New Jersey law requires the parents to support a disabled child indefinitely, but paying child support may not be the best way to provide the needed support.7

Supporting disabled children over age 18 presents its own set of problems. Often the responsibility of the parent of primary residence is going to continue indefinitely; therefore, he or she will continue to need financial assistance from the other parent. However, any funds paid to the residential parent for the ‘adult’ child as child support will be deemed to be the income of the child, and may (depending on the amount) disqualify the child for SSI and Medicaid. Also, the financial needs of the child may well last beyond the lives of the parents.

Here again, a trust can prove useful. A trust for the benefit of a disabled child, known as a supplemental benefits trust (SBT), provides greater flexibility than the SNT because the trust is not funded with the child’s own money. Since a third party (the parent) is the source of the trust funds, there is no requirement for payback provisions to Medicaid or any other entity that might be providing benefits to the child. If the child has his or her own money to protect, it should be placed in an SNT, as discussed above, and not in the SBT discussed here.

The same restrictions as those set forth in the SNT discussion apply with regard to paying for food and shelter if the child is receiving SSI, and income caps apply for Medicaid. The trust need not be for the sole benefit of the disabled child, and can have remainder provisions upon the child's death or some other triggering event. The trust can receive periodic payments (in lieu of child support), and can be the beneficiary of a life insurance policy. The trust can be set up as an irrevocable life insurance trust, and can own a life insurance policy.

With drafting care, the trust can be as flexible as the parties wish. As with the SNT, the trust can pay food and shelter costs directly, even though this may reduce the amount of SSI the child is receiving. In most instances the receipt of SSI by the child is more important, due to the Medicaid that goes with it, than the actual amount of the SSI award, which is currently approximately $824 per month. As long as the child receives some SSI, he or she will receive the Medicaid benefits.

**Life Insurance Trusts**

Although rarely used, life insurance trusts always have a place in divorce settlements. The trust will own the policy. The terms of the trust can be determined by the parties so the trust provides for the spouse and children during their lifetimes, or during the time of any support obligation, with the policy benefits being paid to others if circumstances have changed, such as the death of a beneficiary.

The trust can call for periodic payments or restrictive payments for certain expenses. It can sprinkle the benefits among various people under circumstances spelled out in the trust. Additionally, the trust can contain term insurance that will expire at the end of the obligation, or some form of permanent insurance.

Properly structured, a life insurance trust can even hold employee group life insurance. Again, because the life insurance policy and proceeds do not belong to the disabled person, the flexibility to meet the obligations to the disabled person and future desires of the obligated spouse/parent are enormous.

**Conclusion**

In summary, disabled spouses and children in divorce situations need special considerations. Thought must be given to seeking and maintaining third-party benefits, whether from a public or private source. One of the best ways of doing this may be the use of one or more trusts for the benefit of the disabled person. The attorney must look at what is best for the disabled client, within the Rules of Professional Conduct, and, where appropriate, may need to seek a guardian ad litem for the divorce proceedings,8 or a full guardianship, the discussion of which is beyond the scope of this article. 88

**Endnotes**

2. 42 U.S.C. §§1396p(d)(4)(A) et seq.
3. JP v. DMAHS, 392 N.J. Super. 295

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Estate plans for clients with disabled loved ones should address the usual factors that arise when drawing any competent estate plan. These include naming initial and contingent beneficiaries, minimizing taxes, apportioning taxes among beneficiaries, designating fiduciaries, according fiduciary powers, and designing trusts. However, a panoply of other considerations also arise when an estate beneficiary may have serious disabilities.

**Special Estate Planning Considerations**

While some people with serious disabilities have very successful careers (e.g., Franklin Roosevelt, Stephen Hawking, and Richard Pryor), this article focuses on estate planning to benefit individuals who cannot support themselves due to serious disabilities. They come in all shapes, sizes, and stations in life. While some have debilitating conditions that lead to government placements in group homes or other facilities, others live in the community in similar manner to those without disabilities. Thus, an individual with severe mental retardation or autism may not be likely to travel or live alone. However, parents of a person with schizophrenia, bipolar disorder, paraplegia or mild retardation may expect to fund a home, vehicle, entertainment, and other typical quality of life items, as well as disability-specific needs like accessibility modifications and aides.

Paradoxically, the higher a person with disabilities functions, the more he or she is likely to need financial help from a parent’s estate. This is because government aid typically covers only basic necessities. Thus, it is common for parents to fund a home for a son or daughter who is highly intelligent but cannot work because of schizophrenia or bipolar disorder. However, unless an estate plan is sensitive to this need, the disabled child likely will be forced from the home when the parents die. Even lower-functioning individuals who reside in government-funded group homes, supervised apartments, and other placements once they cease to reside with their parents, still may benefit from privately funded luxuries, case management, and advocacy.

In developing estate plans for clients with disabled loved ones, a lawyer must consider both the intended beneficiary’s likely needs and whether or not public programs will meet them. By preserving eligibility for government aid, an estate plan can address the supplemental needs government agencies do not fund. In contrast, a poorly designed estate plan can disqualify a disabled beneficiary for government benefits that fund essential support and activities. Because some providers do not accept private payment, this may lead to a client’s child with disabilities losing residential and vocational placements. A well-drawn estate plan, however, will make amounts available for needs and wants government aid does not cover while qualifying a disabled beneficiary for public programs.

**Ask the Client**

Do not rely on clients to volunteer whether a loved one has serious disabilities. Ask about the client’s family, but recognize that some clients may be in denial or ashamed of a relative’s impairments. For instance, ‘Junior’ Soprano described one of Tony Soprano’s uncles as “slow,” when he obviously had developmental disabilities, probably mental retardation. Similarly, clients may consider mental illness or addiction as a character failing rather than a disease, or characterize a client as ‘lazy’ when he or she actually is mentally disabled. Unfortunately, it is also common for people with some disabilities to forego government aid because they refuse to admit to mental impairments. Consequently, estate planners sometimes must read between the lines. Where it isn’t clear whether or not an individual with disabilities (especially a young child) may be able to work, it is prudent to plan for the worst and hope for the best.

It also is important to ascertain the kind of disability involved, and refer the client to appropriate sources for aid. For instance, specialized programs may be available for people with developmental disabilities, traumatic brain injury, or other less common conditions. Because these benefits may be targeted toward comparatively limited groups, clients may not even realize help is available. Thus, clients may be sur-
prised to learn that an honor high school student who suffers a debilitating head trauma may qualify for aid from the Division of Developmental Disabilities despite being born without disabilities. Similarly, many parents do not realize that their children with delays may be eligible for early intervention and supplemental education benefits.

Needs may differ substantially depending on the kind and extent of impairment. Different government benefits may be available depending on whether or not a person has been disabled since childhood or worked for a time before becoming disabled. Estate planners also should determine what (if any) government benefits a disabled beneficiary receives, and consider if he or she may qualify for other aid as well. For instance, a child who currently does not receive benefits may qualify at age 18, and benefits may increase or change when a parent dies or retires.

**Government Benefits**

Government benefits provide cash payments, healthcare, subsidized housing, group homes, other disabilities-oriented housing, psychiatric hospitalization, special education, vocational services, personal needs, long-term care, counseling, and other aid for people with serious disabilities. Most programs either are limited to disabled people with only nominal savings and incomes, or require participants with means to pay for goods and services that otherwise would be provided at little or no cost. Nearly all amounts (including gifts, inheritances, insurance, IRAs, and retirement benefits) count against financial caps.

People who cannot work, rarely exceed financial eligibility limitations on their own, unless they are married or worked previously. However, all but the smallest gifts, inheritances, and death benefits are likely to exceed government aid financial caps. Consequently, people with serious disabilities should not normally be outright beneficiaries. Clearly, estate planners who are oblivious to government benefit eligibility requirements may easily disqualify a disabled person from crucial government aid. In addition to being wasteful, disqualification can prove catastrophic because some government programs cannot readily be replaced privately. Although Medicare and some other programs do not base eligibility on finances, it is still advisable to plan with qualification limits for the more common finance-based disability benefits in mind, because a person who does not receive such aid now may need it later.

Ignoring disability issues in estate planning may lead to unpleasant consequences for the lawyer as well. Obviously, a malpractice claim may be brought against a lawyer whose estate plan disqualifies a client’s child or grandchild for valuable disability aid, and lawyers have been disciplined for egregiously impairing government benefit qualification. Therefore, to serve clients and the lawyer’s own interest as well, estate planners either should develop expertise in special needs planning or consult a special needs lawyer when an estate-planning client has loved ones with serious disabilities.

**Special/Supplemental Needs Trusts**

Outright payments generally disqualify a person with serious disabilities for government benefits that base qualification on finances. Even if eligibility can be restored, benefits can be temporarily stopped, some prior benefits may have to be repaid, and other negative consequences may ensue. For instance, outright receipt of an inheritance, insurance death benefit, or IRA may trigger an immediate state claim for over a million dollars to reimburse years of group home residence. In addition, to retain government aid a beneficiary may have to agree to Medicaid repayment down the road. In contrast, a quality special needs plan could avoid any repayment obligation.

Most programs that limit participation by finances count only amounts that an applicant can access for support, which may constitute food, shelter, medical care, or general basic needs, depending on the program. Therefore, to avoid jeopardizing eligibility or giving rise to repayment obligations, never give an individual with serious disabilities outright distributions or support rights from a trust or anyone else. Instead, amounts to benefit an individual with serious disabilities should be paid into trust.

A trust to supplement government disability benefits often is called an SNT, which stands for special needs trust, supplemental needs trust, or supplemental benefits trust, depending on the lawyer’s language preference. Regardless of terminology, an SNT is a trust that leaves distributions within trustee discretion, which can be extremely broad or more limited, depending on the client’s wishes.

To keep from jeopardizing government aid, an SNT must not mandate distributions or give the beneficiary a right to force the SNT to distribute. For instance, where distributions are tied to an ascertainable standard, such as health and support, a trust has an obligation to pay for those items and the trust can be disqualifying. It is particularly important to preclude courts from construing an SNT as having an implied obligation to fund the beneficiary’s support. Of course, special requirements may apply, depending on benefit programs and circumstances.

Nevertheless, SNTs need not be unduly limiting. For example, an SNT can pay for furniture, equipment, transportation, travel, clothes, professionals, accessibility items, entertainment, education, and nearly anything else.

Thoughtfully designed SNTs are drawn with the particular client’s needs in mind, and will not be unduly limiting. For instance, parents who own their child’s townhouse probably want their
SNT to continue to fund housing expenses, even if government aid may be reduced by nominal amounts. Therefore, a cookie-cutter SNT that prohibits payments for shelter or expenditures that could cause a reduction in government aid would frustrate the parents’ intent. Instead, the SNT should permit funding the child’s shelter but minimize any resulting reduction of benefits.

Because paying basic needs like housing costs or food can jeopardize government aid when not done properly, the trustee must administer the SNT with government benefit rules in mind. Even the best-drafted SNT can disqualify a beneficiary for government programs when administered poorly. Therefore, an SNT trustee should consult counsel before funding basic needs or providing cash or valuables to a beneficiary.

Beneficiary and third-party assets should not be combined in the same SNT, because an SNT that contains a beneficiary’s assets may be required to repay Medicaid upon the beneficiary’s death, and meet other requirements detrimental to the interest of the beneficiary. Neither would apply where the SNT is funded only by third parties. For this reason, a separate SNT should be drawn to hold a disabled person’s personal injury recovery and other receipts.

Conclusion

Special needs planning involves the full panoply of considerations that go into designing any quality estate plan, but it also raises daunting considerations unique to individuals who need financial help because of disabilities. Concerns and solutions vary with the type and extent of disability and family circumstances, but SNTs are an integral part of most plans. However, to serve clients well SNTs must be tailored to individual circumstances and goals. Although special needs estate planning can involve broad challenges, it can prove particularly rewarding to reassure a worried client that options are available to provide for a vulnerable loved one after the client passes on.

Endnote


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The Powerful Power of Attorney

by Regina M. Spielberg

The troubling case of Brooke Astor—the New York socialite and philanthropist whose son, Anthony Marshall, was convicted last year of defrauding and stealing millions of dollars from his mother—placed national media attention on the power of a power of attorney. A written instrument by which an individual, known as the principal, authorizes another individual, known as the agent, to perform specified acts on his or her behalf, the power of attorney is an effective planning tool for those who anticipate needing assistance with financial matters.

Ideally, a client executing a power of attorney chooses a trustworthy agent who acts for the client’s benefit, avoiding the need for a guardian, the associated court costs and a public determination of incapacity. By giving another person authority to manage one’s financial affairs, however, the client may risk misuse of the power of attorney by the agent. Adding to the possible risk, power of attorney forms are widely available on the Internet, allowing a principal to sign a simple document that conveys extraordinary powers without the benefit of counsel.

The popularity of the power of attorney has contributed to its use in transactions more complex than originally intended by the law. An unscrupulous agent acting under a broad power of attorney may have authority to conduct transactions that are not in the principal’s best interest, such as transferring property without notifying the principal. In an effort to curtail abuses of powers of attorney, states have adopted statutes that address execution requirements, fiduciary obligations, limitations of the agent’s authority and the standard of care required of the agent.

Background

At common law, powers of attorney terminated upon the incapacity of the principal. A durable power of attorney is created by statute to either survive the incapacity of the principal or become effective upon the incapacity of the principal, permitting the extended management of the principal’s assets. In 1954, Virginia enacted the first durable power of attorney statute that allowed agents to act for an incapacitated principal.

The National Conference of Commissioners on Uniform State Laws (NCCUSL) made statutory durable powers of attorney part of the Uniform Probate Code (UPC) in 1969, to provide an alternative to court-oriented protective procedures. The durable powers of attorney provisions of the UPC were amended, and a separate Uniform Durable Power of Attorney Act was adopted in 1979. At one time followed by most states, it was last amended in 1987.

The current Uniform Power of Attorney Act (UPOAA) was adopted by NCCUSL in 2006 in response to a national review of state power of attorney legislation. This review determined that many states had enacted provisions with respect to areas where the original Uniform Durable Power of Attorney Act was silent, including:

1. authority of multiple agents;
2. authority of a guardian appointed after the execution of the power of attorney;
3. impact of the dissolution of a marriage where the spouse is the agent;
4. portability;
5. authority to make gifts; and
6. standards of agent conduct and liability.

The presumption of the UPOAA is that a power of attorney is durable unless otherwise expressed. It provides a default standard for agent conduct and liability. The UPOAA provides for third-party reliance on the power of attorney and liability for unreasonable refusal to accept the power of attorney. The agent may file for a court order to enforce acceptance of the power of attorney.

An optional statutory form for creating a power of attorney is included in the UPOAA.

The UPOAA addresses legislative trends and best practices, and balances the need for acceptance of an agent’s authority against the need to prevent and redress financial abuse. While all 50 states have power of attorney statutes, only
four—Colorado, Idaho, Nevada and New Mexico—have adopted the UPOAA.

The ‘New’ New York Power of Attorney

Effective Sept. 1, 2009, the New York General Obligations Law governing the power of attorney statute was significantly amended. The changes resulted from eight years of study by the New York State Law Revision Commission. The commission concluded that the potency and easy creation of a power of attorney, when combined with existing statutory gaps and ambiguities, can result in its misuse. These concerns are intensified when the principal is incapacitated and unable to monitor the agent’s actions.

Like the UPOAA, the new New York law provides: 1) a new statutory short form of power of attorney; 2) the form is durable unless it provides otherwise; 3) a third party cannot unreasonably refuse to honor the power of attorney; 4) a third party cannot require an additional form of power of attorney for authority granted in the power of attorney presented; and 5) portability, in that other forms of power attorney may be used in New York, specifically, a power of attorney executed outside of New York that appears to be a statutory form of power of attorney of another jurisdiction at the time of execution.

The statutory power of attorney must be signed, dated and acknowledged by both the principal and the agent. The effective date of the power of attorney regarding an agent is the date when the agent’s signature is acknowledged. As a result, if more than one agent is designated, the power of attorney is effective when all agents have signed the power of attorney and their signatures have been acknowledged. A valid power of attorney executed prior to Sept. 1, 2009, remains valid.

An important change that has received much attention is the statutory major gifts rider (SMGR). Intended to help curb financial abuse, the SMGR governs the agent’s authority to make gifts exceeding $500 per person (or charity) each calendar year. The SMGR governs the agent’s authority to create and fund trusts, designate beneficiaries on retirement accounts and insurance policies, and create joint accounts.

To be valid, the rider must be accompanied by a power of attorney in which the authority (SMGR) is initialed by the principal, and must be executed simultaneously with a properly executed power of attorney. The SMGR itself must be signed in the same manner as a will (i.e., the signature of the principal must be witnessed by two people not named in the SMGR as permissible recipients of gifts). An alternative to the rider is permitted if the non-statutory grant of authority is executed in the same manner as the SMGR.

While there has been some grumbling about the new execution requirements, the purpose is to alert the principal to the significance of granting the agent this type of authority.

Proposed Revisions to the New Jersey Power of Attorney Statute

The New Jersey Law Revision Commission proposed revisions to the New Jersey Revised Durable Power of Attorney Act in December 2009, and solicited public comments until March 12, 2010. The proposed revisions and related tentative report, prepared by Marna L. Brown, counsel to the commission, can be found online at www.njlrcc.state.nj.org.

Like the new New York statute, the proposed revisions are intended to clarify ambiguities and address gaps in the existing statute. For example, proposed Section N.J.S. 46:2B-20.2 adds a definitions section and replaces the term “attorney-in-fact” with “agent.” The term “financial institution” expands the application of the proposed statute to include not only banks but securities brokers and dealers, insurance companies, trust companies and other entities.

Under proposed Section N.J.S. 46:2B-20.11, no third party, including financial institutions, may refuse a power of attorney because it is not on a form prescribed by the third party. Consistent with existing law, the proposed section also provides that no third party, including financial institutions, may refuse a power of attorney due to a lapse of time since the document’s execution. Third parties who violate the statute will be subject to action by the principal, agent, guardian or conservator of the principal, spouse, domestic or civil union partner, child or parent of the principal under proposed Section N.J.S. 46:2B-20.13.

Every power of attorney will be durable unless the document expressly provides otherwise under the proposed revision. Co-agents shall act jointly unless the document expressly provides otherwise under the proposed revision.

Consistent with existing law, the agent under a power of attorney does not have authority to make gifts or transfers unless that authority is expressly granted. The same express authority is required for an agent to: 1) designate, change or revoke beneficiaries under insurance policies, annuities, employment benefits and retirement plans; 2) create, amend, revoke or terminate inter vivos trusts; 3) modify, terminate, or change beneficiaries of a transfer on death account.

The commission initially considered including a statutory form power of attorney, similar to the New York statute, in the proposed revision, but ultimately did not due to the unfavorable response from the New Jersey legal community. Instead, the proposed revisions provide drafting guidelines at N.J.S. 46-2B-20.6; Section (a) provides required guidelines and Section (b) provides illustrative guidelines.
The power to “conduct health care billing, recordkeeping and payment,” as described in N.J.S. 46:2B-20.35, will authorize the agent to act as a representative under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to access protected health information and to communicate with healthcare providers, but not to make healthcare decisions under proposed Section N.J.S. 46-2B-20.5f.

A power of attorney must be signed by the principal and witnessed and acknowledged by two individuals, neither of whom may be the agent, and a notary public or other officer authorized to take acknowledgments, in order to be valid under the proposed statute. The document is effective when signed by the principal. The agent’s signature is not required.

**Conclusion**

Under the proposed revisions of the power of attorney statute, New Jersey will join the trend toward more detailed, complex powers of attorney statutes. Some attorneys feel such statutes unnecessarily complicate a simple, useful planning tool. But the availability of power of attorney forms on the Internet allows people to sign this incredibly powerful document without the benefit of counsel, thereby increasing the potential for misuse. Strict statutory standards for document execution, agent authority and fiduciary obligations are intended to help the principal understand the effect of the power of attorney.

**Endnotes**

7. Id.
8. Id. at §301.

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Recent Revisions to the Social Security Administration’s Program Operations Manual System (POMS) Relating to Special Needs Trusts

by Thomas D. Begley Jr.

In January 2009, the Social Security Administration (SSA) made a number of changes to the Program Operations Manual System (POMS) relating to both first-party and third-party special needs trusts. These changes affect the drafting and administration of special needs trusts and the drafting of court orders establishing self-settled special needs trusts. Pooled trusts are also covered in the revisions. This is a brief review of those changes.

General

Grantor Trust

The POMS states that, subject to state law, a grantor trust is one in which the grantor of the trust is also its sole beneficiary.1 State law on grantor trusts varies.2 The grantor is the person whose money is used to fund the trust. A grantor trust is a self-settled special needs trust. The term “grantor trust,” as used in the POMS, is different from the term as used in the Internal Revenue Code. This addition to the POMS clarifies that state law needs to be consulted regarding whether a self-settled special needs trust would be a grantor trust under the POMS.

Third-Party Trust

A third-party trust is established with assets of someone other than the beneficiary.1 This provision clarifies that a third-party special needs trust is funded with assets of someone other than the beneficiary, while a first-party trust is funded with assets of the beneficiary.

Assignment of Income/Child Support and Alimony Trusts

A legally assignable payment that is assigned to a trust is income for Supplemental Security Income (SSI) purposes, unless the assignment is irrevocable. For example, child support or alimony payments made directly to a trust as a result of a court order are not income.1 This amendment to the POMS clarifies that child support or alimony payments paid directly into a trust as a result of a court order are not income, as long as the assignment is irrevocable.

Assets of an Individual

The POMS clarifies that special rules apply to trusts established with assets of an individual on or after Jan. 1, 2000.4 There is an example of a disabled SSI recipient over age 18 who receives child support, which is assigned by court order, directly into the trust. Since the child support is the SSI recipient’s income, the recipient is the grantor of the trust, and the trust is a resource unless it qualifies as a self-settled special needs trust.6 This clarifies that child support is the recipient’s income and must be diverted to a first-party rather than third-party special needs trust. The same reasoning would apply to alimony.

Additions to Trust After Age 65

If the trust contains the irrevocable assignment of the right to receive payments from an annuity or support payments made when the trust beneficiary was less than 65 years of age, annuity or support payments paid to a special needs trust are treated the same as payments made before the individual reached age 65, and do not disqualify the trust from the special needs trust exception.7 For the first time, the POMS clarifies that payments under a structured settlement received after age 65 do not disqualify the trust from self-settled special needs trust treatment, as long as the structure was in place prior to age 65.

Drafting Requirements

Spendthrift Clause or Spendthrift Trust

A spendthrift clause or trust prohibits both voluntary and involuntary transfers of the beneficiary’s interest in the trust income or principal. This means that the beneficiary’s creditors must wait until money is paid from the trust to the ben-
ficiary before they can attempt to claim it to satisfy debts. It also means that a beneficiary cannot sell his or her right to receive payments from the trust to a third party for a lump sum.

A valid spendthrift clause would make the value of the beneficiary’s right to receive payments not countable as a resource. If the beneficiary’s right to receive payments from the trust could be sold by the beneficiary for a lump sum, the value of the beneficiary’s right to receive monthly payments would be counted as a resource. If an individual can sell his or her beneficial interest in the trust, that interest is a resource. If the beneficiary has the power to revoke or terminate the trust and gain access to trust assets, the trust may be a resource to the beneficiary. If there is a valid spendthrift clause, the beneficiary cannot sell the trust assets, so they are non-countable. The key is whether the trust assets can be sold.

Use the term “spendthrift clause” in the document, rather than “protective provision” or similar language.

Revoke

The grantor of a trust may have the power or authority to revoke (i.e., reclaim or take back) the assets deposited in the trust. If the individual at issue is the grantor of the trust, the trust will generally be a resource to that individual if he or she can revoke it and reclaim its assets. However, if a third party is the grantor of the trust, the trust will not be a resource to the beneficiary (emphasis added) of the trust merely because the trust is revocable by the grantor. If the beneficiary had the right to revoke the trust, its assets would be considered to be available to the beneficiary. Include language in the document prohibiting the beneficiary from revoking the trust.

Terminate

In rare instances, a trustee or beneficiary of a third-party trust can terminate the trust and obtain the assets for him or herself. This new section simply contains the definition of “termination.” Previously, the POMS stated that if a beneficiary had a right to revoke a trust, the assets would be countable to the beneficiary. This provision simply states that if the beneficiary has the right to terminate the trust, the assets in the trust would be considered countable assets to the beneficiary.

If a special needs trust includes a provision allowing for termination of the trust during the lifetime of the beneficiary, and distribution of the trust assets to the beneficiary, the assets in the trust would be considered available. If the termination provision includes direct payment to a third party other than the beneficiary, the “sole benefit of” requirement would be violated and the trust would be countable to the beneficiary as a resource.

Include language in the document prohibiting the beneficiary from terminating the trust. Do not include language in a self-settled special needs trust permitting termination of the trust during the lifetime of the beneficiary.

Payback Provisions

According to the law in most states, the state is not considered a residual or contingent beneficiary, but is a creditor, and the reimbursement is payment of a debt unless the trust instrument reflects a clear intent that the state be considered a beneficiary rather than a mere creditor. In drafting a self-settled special needs trust care should be taken to ensure language is included naming the trust as a creditor rather than as a beneficiary. State law must be consulted. Draft the trust document to identify the state as creditor rather than a beneficiary.

A Medicaid payback may not be limited to any particular period of time (i.e., payback cannot be limited to the period of establishment of the trust). This clarifies a previously gray area. This section of the POMS makes clear that a Medicaid payback must include any funds paid on behalf of the person with disabilities since birth. The payback is not limited to Medicaid expenditures made after the trust was established. Include language in the trust document defining the payback requirement to include all medical assistance paid during the lifetime of the beneficiary.

Established for the Benefit of the Individual/Sole Benefit of

SSA has interpreted this provision to require that the trust be for the sole benefit of the individual. The special needs trust will be disqualified if it contains provisions that:

- provide benefits to other persons or entities during the lifetime of the beneficiary, or
- allow for termination of the trust prior to the individual’s death and payment of the corpus to another individual or entity (other than the state(s) or another creditor for payment for goods or services provided to the individual).

For the first time, the POMS addressed the issue of what happens if a trust provides for termination prior to the individual’s death. Although not clearly written, it is intended to mean that a valid self-settled trust cannot allow for termination or revocation prior to the beneficiary’s death. Upon death, it cannot allow for payment to another individual or entity before the state is paid back, except for payment to another creditor for goods or services provided to the individual, presumably before death.

Use the words “for the sole benefit of” in the self-settled special needs trust document.

Who Established the Trust?

A party must have “legal authority”
to establish a trust. Otherwise, the trust will be invalid, or the corpus will be countable to the beneficiary. The POMS clearly states that a legally competent disabled adult may transfer his or her own assets into the trust, or another individual acting under a validly created power of attorney may establish the trust or transfer the assets. However, the disabled individual may both sign and fund a pooled trust.

The POMS clarifies a frequent misunderstanding in terminology caused by the statute, which caused problems in meeting the “legal authority” requirement. “Established” or “created” have two meanings that were not clearly delineated in the original POMS. The first establisher or creator is the party that took physical action to sign the trust, and the second type of establisher or creator—the traditional type under trust law—is the beneficiary who self-settled the trust corpus. This has been respectively clarified with meanings of “established through the actions of” a defined individual or court to sign the trust, and “established by” the beneficiary contributing funds.

In the case of a trust established through the actions of a court, the creation must be by court order, effectively having the judge sign the trust, or ordering a party to sign the trust under court order. If a court only allows or assents to a trust signed by a third party (other than a parent, grandparent, or guardian), then the trust will be invalid. However, the disabled individual may both sign and fund a pooled trust.

Consider using the term “establisher” to identify the entity signing the trust. Use the term “grantor” for the beneficiary funding the trust. A trust may be established (signed) through the actions of a qualified individual under a validly created power of attorney, and the trust corpus may also be established (funds transferred into the trust) under a validly created power of attorney granted by the beneficiary.

A validly drafted power of attorney cannot be used to establish a trust through the actions of either a parent or grandparent, but can be used to fund the trust with the assets of the beneficiary. However, a trust established (emphasis added) under a power of attorney will result in a trust that SSA considers established through the actions of the disabled individual him or herself, because the power of attorney merely establishes an agency.

Never draft a self-settled special needs trust where the parent or grandparent uses a power of attorney to establish (sign) the trust, unless the power of attorney specifically allows the agent to do so on behalf of the principal.

The new POMS tries to distinguish the different duties a guardian may perform in establishing a trust through its actions (signing), and funding a trust (establishing) as guardian of the incompetent beneficiary. In effect, the guardian may wear two hats, and must distinguish its duties in signing and funding the trust or run afoul of lacking “legal authority” to establish either aspect of the trust. Care must be taken to distinguish that the different actions taken by the same fiduciary are separate and distinct.

If a person appointed guardian performs different duties, specifically state this in the document. For example, if the guardian establishes the trust through its actions (sign the trust), cite the court order authorizing it to do so. Likewise, if transferring funds into the trust, state the legal authority, according to court order or state law, allowing it to do so. If acting in another capacity, such as a trustee, distinguish the different fiduciary duties as being independent of each other.

The SSA considers the guardian, when performing traditional duties for the individual such as transferring the individual’s assets into the trust, to be akin to a legal alter ego of the individual.

What is the effect of this language on a trigger trust? There should not be a transfer of asset penalty if the trust converts to a self-settled special needs trust, commonly called a (d)(4)(A) trust, because these trusts are specifically exempt from transfer of asset penalties. Use caution.

**Administration**

**Distributions Considered Income**

Distributions from the trust to third parties that result in the beneficiary receiving non-cash items are countable as income in the month of receipt, if the items would not be a partially or totally excluded non-liquid resource if retained into the month after the month of receipt. This rule simply distinguishes that payments to third parties for in-kind goods and services that are not for food or shelter are not countable income to the beneficiary as long as countable resources are not purchased (i.e., a second vehicle). Otherwise, it clarifies that purchases of countable resources are also considered income in the month of receipt.

**Distributions Not Considered Income**

Disbursements made from the trust to a third party that result in the beneficiary receiving non-cash items (other than food or shelter) are not income if those items would become a totally or partially excluded non-liquid resource if retained into the month after the month of receipt. This is a new section that clarifies that distributions to third parties for purchases of non-countable assets are not income.

**Distributions Not to or for the Benefit of the Beneficiary/Transfer of Assets**

If a trust is established with assets of the individual or his or her spouse, any disbursement from the trust that is not made to or for the benefit of the individual is considered a transfer of resources as of the date of the payment, and is not considered income to the individual. This provision simply clarifies that distributions from a self-settled special
needs trust for the benefit of someone other than the person with disabilities would be considered a transfer of assets.

**Disbursements for Credit Card Bills**

If a trust pays a credit card bill for the trust beneficiary, whether the individual receives income depends on what was on the bill. If the trust pays for food or shelter items on the bill, the individual will generally be charged with in-kind support and maintenance up to the presumed maximum value. If the bill includes non-food, non-shelter items, the individual usually does not receive income as a result of the payments unless the item received would not be a totally or partially excluded liquid resource the following month. For example, if the credit card bill includes restaurant charges, payment of those charges results in initial support and maintenance. If the bill also includes purchase of clothing, payment of clothing is not income.

This is the first time the POMS clarifies how payment of credit cards will be treated, and is a very important provision for trustees to understand and follow. However, credit cards cannot be used by the individual to obtain cash from an ATM without the cash being counted as income, and if any goods obtained by the credit card are then sold by the individual, the cash received will count as income.

**Court Order**

In the case of a trust established through the actions of a court, the creation of the trust must be by a court order. Approval of a trust by the court is not sufficient. A clarification under the POMS is that the court must order that the trust be established rather than simply approving a trust established by an ineligible party. Appropriate language must be inserted in each court order. Draft the trust so the judge orders a party, other than the beneficiary or spouse, to sign it.

**Conclusion**

The revised POMS clarify a great deal of SSI policy. Practitioners who designed special needs trust forms prior to the revisions would be advised to revisit those forms to incorporate the changes required by the POMS.

**Endnotes**

1. POMS SI 01120.200B.2.
2. POMS SI 01120.200B.8.
3. POMS SI 01120.200B.17.
4. POMS SI 01120.200G.1.d.
5. POMS SI 01120.201B.7.
6. POMS SI 01120.201C.2.b.
7. POMS SI 01120.203B.1.c.
8. POMS SI 01120.200B.16.
10. POMS SI 01120.200D.1.b.
11. POMS SI 01120.200B.20; POMS SI 01120.200D.1.b.
12. POMS SI 01120.200H.1.b.
13. POMS SI 01120.203B.1.h.
14. POMS SI 01120.203B.1.e.
15. POMS SI 01120.203B.1.g.
16. POMS SI 01120.203B.1.f.
17. POMS SI 01120.203B.1.f.Note.
18. POMS SI 01120.203B.19.
19. POMS SI 01120.200E.1.a; POMS SI 01120.201I.1.a.
20. POMS SI 01120.200E.1.c.
21. POMS SI 01120.200E.2; POMS SI 01120.201I.1.c.
22. POMS SI 01120.201I.1.d.
23. POMS SI 01120.201I.1.e.
24. POMS SI 01120.203B.1.f.

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Guardianship Applications and Attorney’s Fees

by Brenda McElnea

All attorneys need to know how their fees for services are going to be paid and at what rate, in order to keep their doors open and their lights on. The payment of fees in guardianship applications differs from what is known as the American Rule under which each side ordinarily bears his or her own counsel fees, and the rate of payment may vary with the attorney’s role in the matter.

Plaintiff’s Attorney

Typically, the plaintiff’s attorney will be contacted when a family member needs to make medical decisions for and/or manage the estate of an individual who does not have an effective durable power of attorney and/or a healthcare proxy, and who now lacks the mental capacity to execute those documents. Under those circumstances, plaintiff’s attorney will commence an action for a determination of mental capacity and the appointment of a guardian. Plaintiff’s attorney should bill on an hourly basis, keeping thorough time records and records of disbursements so he or she may prepare and submit a certification of services at the time of the hearing.\(^1\)

The action for determination of mental incapacity is governed by comprehensive court rules that set forth the tasks and responsibilities of plaintiff’s attorney;\(^2\) and by statutes.\(^3\) In the intake process, the attorney must identify the interested parties with respect to the alleged incapacitated person (AIP), for example the spouse, children, brothers and sisters, and parents, if living, as well as the institution in which the AIP is then placed. With respect to each individual, his or her age, residence, place of employment and telephone numbers must be obtained. The attorney will advise the plaintiff who has priority to serve as guardian in accordance with the court rules and of the existence of the Office of the Public Guardian;

The attorney works with the plaintiff to select appropriate physicians and psychologists, and to schedule these appointments. The attorney and his or her staff works closely with the doctors or the doctor and psychologist, and their staffs, advising each of the time constraints for these documents, and what information the affidavit must contain about their own background and qualifications and about the physical health and the extent of the mental capacity of the AIP.

There are now both plenary and limited guardianships.\(^7\) The attorney must work with the doctors and psychologists to determine if the AIP has sufficient capacity to retain the right to manage specific areas, such as residential, educational, medical, legal, vocational or some financial decisions, and if so, to state that with specificity in the doctor’s or psychologist’s affidavit, and to state as well the extent to which the AIP is unfit and unable to govern him or herself and manage his or her affairs.

While the court rule speaks of affidavits, it is often best to use a certification instead, to expedite the matter.

Rule 4:86-2(a) also requires an affidavit that is detailed and specific regarding the AIP’s property. This affidavit must set forth the nature, location and fair market value of all real estate in which the AIP has or may have a present or future interest, stating the interest, describing the real estate fully or by metes and bounds, and stating the assessed value of the

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1. Plaintiff’s proposal and has an equal or superior right under the court rules to serve.
2. The action will be brought in New Jersey Superior Court, Chancery Division, Probate Part in the county where the AIP is domiciled, and will be initiated by way of a verified complaint.\(^1\) In addition to drafting the complaint, the attorney must determine the information necessary to draft the accompanying affidavits required by the court rules. Pursuant to Rule 4:86-2(b), affidavits are required of two qualified physicians or one qualified physician and one qualified practicing psychologist, each of whom has examined the AIP within 30 days prior to the filing of the complaint.\(^4\)
3. The attorney must work with the plaintiffs and psychologists to determine if the AIP has sufficient capacity to retain the right to manage specific areas, such as residential, educational, medical, legal, vocational or some financial decisions, and if so, to state that with specificity in the doctor’s or psychologist’s affidavit, and to state as well the extent to which the AIP is unfit and unable to govern him or herself and manage his or her affairs.
4. While the court rule speaks of affidavits, it is often best to use a certification instead, to expedite the matter.
5. Rule 4:86-2(a) also requires an affidavit that is detailed and specific regarding the AIP’s property. This affidavit must set forth the nature, location and fair market value of all real estate in which the AIP has or may have a present or future interest, stating the interest, describing the real estate fully or by metes and bounds, and stating the assessed value of the

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court is satisfied with the sufficiency of the complaint and supporting affidavits, it signs the order for hearing fixing the hearing date for further proceedings. Pursuant to Rule 4:86-4(a), the order will require that at least 20 days’ notice be given to the AIP and all parties in interest, including those named above and any person named as attorney-in-fact in any power of attorney, any healthcare proxy named in a healthcare directive of the AIP, and counsel appointed for the AIP by the court, whose duties are discussed below.

The court-appointed attorney for the AIP will also bill on an hourly basis. The hourly rates of appointed counsel are generally capped in most counties. Further, attorneys who seek to be on the list for court appointment should be aware that they may be appointed in matters where there are little or no funds, and they may not receive any compensation.

Pursuant to Rule 4:86-4(b), court-appointed counsel must personally interview the AIP; make inquiry of and speak to persons having knowledge of the AIP’s circumstances, his or her physical and mental state and his or her property; and make reasonable inquiry regarding the whereabouts of any will, powers of attorney or healthcare directives previously executed by the AIP and whether the AIP has any interests as a beneficiary of a will or a trust. The order for hearing will state the number of days before the hearing that the court-appointed attorney must file his or her report with the court and serve the plaintiff’s attorney and other parties that have formally appeared in the matter. Pursuant to Rule 4:86-4(b), court-appointed counsel must personally interview the AIP; make inquiry of and speak to persons having knowledge of the AIP’s circumstances, his or her physical and mental state and his or her property; and make reasonable inquiry regarding the whereabouts of any will, powers of attorney or healthcare directives previously executed by the AIP and whether the AIP has any interests as a beneficiary of a will or a trust. The order for hearing will state the number of days before the hearing that the court-appointed attorney must file his or her report with the court and serve the plaintiff’s attorney and other parties that have formally appeared in the matter.

Rule 4:86-4(b) also provides that the report must be filed at least three days prior to the hearing date. This report generally sets forth the social, physical and mental health background of the AIP, the family background, and the suitability of the proposed guardian. It identifies information counsel obtained by inquiry; counsel’s recommendations concerning the court’s determination of the issue of incapacity and the suitability of less restrictive alternatives, including limited guardianship; and whether a case plan for the AIP should be submitted to the court at a later date. The report must also make recommendations concerning whether good cause exists for the court to order that any power of attorney, healthcare directive, or revocable trust created by the AIP be revoked or the authority of the person or persons acting thereunder be modified or restricted. The author has seen advance instruction directives preserved, and has only seen powers of attorney and healthcare proxies revoked when a guardian has been appointed.

The AIP does not have to accept court-appointed counsel, and is free to obtain his or her own counsel. In such an event, the newly selected counsel must notify the court and court-appointed counsel at least five days prior to the hearing. It may take a decision by the court to determine who the AIP’s counsel is. For example, in a contested guardianship matter, an adult child who sought to be named as guardian had been named by the AIP as his power of attorney some years ago. As power of attorney, the adult child hired counsel for his father and separate counsel for himself. There was some question regarding whether his hiring of counsel for the AIP was a conflict of interest.

Issues such as this are generally argued and resolved at case management hearings attended by all counsel prior to the hearing regarding incapacity.

The role of court-appointed counsel or the AIP’s counsel is to advocate for the wishes and desires of the AIP; to maintain a normal attorney-client relationship with the AIP to the extent possible; and to protect the rights of the AIP, including the right to make decisions concerning specific matters, absent putting the AIP at risk of harm.

Guardian Ad Litem

However, pursuant to In re M.R. and Rule 4:86-4(d), if special circumstances are brought to the court’s attention by formal motion or otherwise, at any time
prior to the entry of a judgment, the court, in its discretion, may appoint a
guardian *ad litem*, in addition to counsel
for the AIP, to evaluate the best interests
of the AIP and to present that evaluation
to the court. In sum, the guardian *ad litem* is to serve as the eyes and ears of
the court.

The guardian *ad litem* may be
required where the AIP has wishes that
are not in his or her best interests, or
where the guardianship is contested
with regard to whether the AIP is incapa-
citated and/or who should serve as
guardian. The guardian *ad litem* must be
in contact with all counsel, all parties to
the action and all of the individuals
court-appointed counsel contacted.
Again, this attorney has significant
interviewing and writing to do. He or
she will also bill hourly and present a
certification of services to the court at
the hearing.

**Other Interested Persons Appearing
by Counsel and the Race to the
Courthouse for Counsel Fees**

Pursuant to Rule 4:86-5, if any person
receiving notice intends to appear by an
attorney, he or she shall, not later than
days before the hearing, serve and
file an answer, affidavit, or motion in
response to the complaint. This rule
applies to contested guardianships,
where families are arguing about
whether the individual is, in fact, inca-
pacitated, and/or about who should
serve as guardian. In general, attorneys
prefer to deal with a party who is repre-
sented by counsel, rather than a *pro se*
litigant. The author suggests the current
fee structure may unwittingly encourage
*pro se* litigants.

Rule 4:86-4(e) provides that compensa-
tion of the attorney for the party seek-
ing guardianship, court-appointed
counsel, and of the court-appointed
guardian *ad litem*, if any, may be fixed
by the court to be paid out of the estate
of the alleged incapacitated person, or
in such other manner as the court shall
direct. No mention is made of compensa-
tion of the counsel for other parties.
Accordingly, pursuant to this rule, if the
AIP is in fact incapacitated and the fam-
ily members are at war over who should
be named as guardian, the family mem-
ber who files the guardianship action
first is in the driver’s seat for getting
paid from the AIP’s estate.

The fees in contested matters can spi-
ral up quickly, and a typical middle-class
family member would not likely have
the means to pay for his or her own
legal fees, forcing them either to go for-
ward *pro se* or withdraw and not be
heard.

In an unpublished New Jersey appel-
late court opinion, *In the Matter of Joseph
Scott Morrison*, a case with a convoluted
procedural history, a guardianship
action was first filed in New Jersey by
Catherine S. Bogert, girlfriend of Joseph
Scott Morrison, who was ultimately
appointed his guardian. Subsequent to
that filing, but before the New Jersey
chancery court had ruled on the issue of
incapacity, the AIP’s daughter filed a
guardianship action in Florida and the
New Jersey chancery court deferred. The
New Jersey chancery court awarded
Bogert attorney’s fees and costs of
$79,288.59.

In the Florida action, the AIP was
adjudicated incapacitated; however, the
Florida appellate court reversed the
order appointing the AIP’s daughter as
his guardian and remanded the case to
the trial court to enter a stay of the pro-
ceeding pending resolution of the
guardianship proceeding in New Jersey.
Thereafter, the daughter of the AIP filed
a verified complaint for guardianship
for a non-resident in New Jersey, and
the New Jersey chancery court entered
an order that gave full faith and credit
to the Florida order that declared Morri-
sion incapacitated, and, *inter alia*,
declared Bogert an interested person
and allowed her to intervene, since her
initial guardianship petition had been
dismissed.

The daughter of the incapacitated
person appealed from the New Jersey
chancery court order granting attorneys’
to Bogert, stating the fee award was
unauthorized by law because the find-
ing of incapacity and the appointment
of a guardian did not occur within the
action instituted by Bogert. The appel-
late court upheld the award of fees to
Bogert, stating that in these competing
guardianship actions, Bogert had filed
her action first, and but for the actions
of the incapacitated person’s daughter
in defiance of the New Jersey proceed-
ing Bogert would have successfully
accomplished her goal of appointment
of a guardian for Morrison. Regarding
the amount of the fees, the court stated
that while they were higher than is typ-
cally awarded in these types of cases,
many of the costs incurred by Bogert
were due to the incapacitated person’s
intransigence and defiance of the New
Jersey proceeding by the incapacitated
person’s daughter.

The author has found many attor-
neys do not understand that their fees
are not authorized to be paid from the
incapacitated person’s estate if they rep-
resent a party who is not the plaintiff.
This may derive from the fee structure
permitted in a probate action. Rule 4:42-
9(a)(3) provides that “(i) if probate is
granted, and it shall appear that the
contestant had reasonable cause for
 contesting the validity of the will or
codicil, the court may make an
allowance to the proponent and con-
testant, to be paid out of the estate.”
The rule continues, “(i) in a guardianship
action, the court may allow a fee in
accordance with R. 4:86-4(e) to the
attorney for the party seeking guar-
dianship, counsel appointed to represent the
alleged incapacitated person, and the
guardian *ad litem*."

As is apparent, there is no authori-
ization to pay the contestant, even if he
or she had reasonable cause. Frequently, when a resolution to the matter can be reached among all counsel prior to the hearing, the solution to the problem is to place the settlement on the record and agree to payment of all attorney fees at an agreed-upon hourly rate, subject to the submission of an affidavit of services, the inclusion of the fees in the judgment, and the court’s approval. Again, counsel for a party who is not a plaintiff cannot be guaranteed payment of his or her fees from the outset.

Factors in Determining Reasonable Fees

In the opinion set forth in In re Landry, decided before the changes to Rule 4:42-9(3) and 4:86-4(e), effective Sept. 1, 2006, the court concluded that the superior court had the authority to award attorney’s fees to counsel for the party filing the guardianship action for appointment of a guardian for a person who is ultimately actually adjudicated to be incapacitated. The court held that the model form of judgment then promulgated by the New Jersey Supreme Court to be used in actions brought pursuant to Rule 4:86, which judgment included specific clauses to be used to confirm the amount of fees awarded to the attorney representing the plaintiff, impliedly authorized such an award.

The Landry opinion also outlined the factors “which should be considered in determining whether an award of fees is justified in a specific case, and the amount of the award which would be appropriate,” and while addressing plaintiff’s counsel, these factors continue to be relevant for all counsel and have an impact on fee awards. Specifically, the court stated that a party seeking an award of attorney’s fees must meet the following requirements:

1. Any application for fees must be supported by an affidavit of service, as required by Rule 4:42-9(b);
2. An applicant for fees shall demonstrate that the fees are reasonable and appropriate, both in terms of the hourly rate requested and the amount of time devoted to the matter;
3. An applicant for fees shall discuss the plaintiff’s motivation in pursuing the action for guardianship;
4. An applicant for fees shall discuss whether the plaintiff was primarily concerned with protecting the incapacitated person, or motivated by some other interest;
5. An applicant for fees shall discuss if the plaintiff has a potential interest in the incapacitated person’s estate;
6. An applicant for fees shall discuss the financial circumstances of both the incapacitated person and the plaintiff in determining whether fees should be awarded.

Of course, the financial needs of the incapacitated person will affect the size of the fees awarded. For example, if the incapacitated person requires placement in an assisted-living facility that does not take Medicaid, that person will need to preserve his or her assets more than an incapacitated person who requires placement in a nursing home and who will qualify for Medicaid.

While there are times when fees cannot be paid until one or more of the incapacitated person’s assets are sold, the attorney should consider asking for the fees to be paid by the guardian within a given number of days, for example 45 days from the date the judgment is signed. It is not uncommon for it to take awhile for plaintiff’s attorney to obtain the bond, but guardians may also dawdle somewhat in getting qualified. Making the payment of fees to the physicians or physician and psychologist who performed the examinations and the attorneys a priority within a reasonable time frame is fair to all.

Actions to Take to Get Paid by a Client

In seeking payment from a client, the foremost point is to make sure the retainer agreement clearly states the client is responsible for attorney’s fees to the extent that they are not paid from the incapacitated person’s funds. If only a portion of the attorney’s fees are paid from the incapacitated person’s funds, the attorney may state that the client will be responsible for the fees that remain unpaid. The agreement may also cap the amount that will be paid out-of-pocket from the client, and/or reduce the regular hourly rate.

To the extent that a client has an account receivable that is substantial given his or her economic means, the attorney can offer the client a payment plan, to pay over time. Unfortunately, if all else fails, the attorney can warn the client that he or she is going to sue for fees, and that the client has the right to seek fee arbitration. That is a long and arduous route for the attorney, and one hopefully to be avoided.

With regard to payment by the court-appointed guardian, the author suggests that the judgment state not only the amount to be paid to each attorney and physician, but also that each be paid coming, court-appointed counsel can be asked to report this failure to the court and have the guardian discharged for failure to perform his or her duties.

Endnotes

1. R. 4:42-9(b).
2. R. 4:86-1 et seq.
6. R. 4:82-2(b).
12. Id.
15. R. 4:42-9(d).
17. Id. at 409.
18. Id. at 410.

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Mediation as a Tool in Contested Guardianship Proceedings

by Sharon Rivenson Mark

Attorneys who represent clients in contested guardianship proceedings know how bitter and divisive these cases can be. Contested chancery court matters, whether guardianship or probate proceedings, are frequently used by the parties as a weapon. In guardianship proceedings these hostilities can harm the incapacitated person or the estate of the incapacitated person rather than safeguard the person or property of the alleged incapacitated person. The contest may result from lack of communication or mistaken communication, and is often fraught with extreme emotion. The incapacitated person often becomes the tool to address family issues that have caused intra-family struggles for years. Having a court decide the ‘winner’ and the ‘loser’ in such cases is not likely to solve the underlying problems or achieve a peaceful coexistence.

What is Mediation?

Mediation and arbitration, also known as alternative dispute resolution, have been used for some time by courts to help resolve civil cases. Their use in probate proceedings has been more limited, but is expanding.

Arbitration is a time-tested, cost-effective alternative to litigation. It is the submission of a dispute to one or more impartial persons for a decision, known as an award. Awards are made in writing, and are generally final and binding on the parties in the case.

Mediation is a dispute resolution process in which an impartial third party—the mediator—facilitates negotiations among the parties to help them reach a mutually acceptable settlement. The major distinction of mediation is that a mediator does not make a decision about the outcome of the case. The parties, with the assistance of their attorneys, work toward a comfortable solution.

Mediation has its drawbacks. The process is non-binding; therefore, neither party is required to accept the mediator’s proposed settlement agreement. The parties to a mediation may or may not have an attorney present, and the attorneys serve as advisors, not participants in the process.

Mediation should ideally be held in a neutral setting. The typical mediation session begins with a brief opening statement by the mediator, followed by a dialogue between the parties. During the session, the mediator may meet privately with each party, and the contents of the discussions are confidential unless the party authorizes the mediator to divulge information.

A mediation session terminates when the parties reach an agreement, or when either party wishes to terminate. An agreement reached in mediation is binding, and can be the basis of judicial enforcement. The earlier a case can be referred to mediation, the greater the likelihood the parties can resolve their dispute at cost savings to themselves and the court.

Mediators can also help the parties determine just how much discovery is needed. Even if discovery has been completed, settlement negotiations have been unsuccessful, or the parties are close to a trial date, the mediation process may still help the parties reach a mutually acceptable agreement.

Mediation Issues in Guardianship Proceedings

Mediation in guardianship proceedings can involve many substantive areas, including issues such as caregiver arrangements, healthcare, financial planning, long-term care, housing and living arrangements, family dynamics, lifestyle choices, and driving.

Capacity to mediate is always an issue in and of itself. The capacity determination itself cannot be a subject for mediation. As the court held in Guardianship of Macak:

[a]n incapacitated person cannot enter into a consent order declaring him to be incapacitated nor can he consent to the appointment of a plenary guardian. An incapacitated person by definition is unfit and unable to govern himself or herself and to manage his or her affairs, R. 4:86-2(b)(6), and hence cannot “settle” a guardianship action in such a fashion. See
N.J.S.A. 38:1-2. The obvious contradictions inherent in such a procedure are discussed properly and at length in the cogent report of the guardian ad litem. Further, as this case illustrates, the potential for overreaching and undue influence is unacceptably high. Even if the parties agree that the court can consider the reports of the examining doctors without requiring their testimony, R. 4:86-6(a), and even if the alleged incapacitated person chooses not to testify, the court must still independently consider all of the evidence, including the doctors’ reports and the report of the court appointed attorney, and must make findings by clear and convincing evidence as to whether the person is incapacitated.2

Mediation can and should be a tool in other aspects of the guardianship proceeding, however. The court in Guardianship of Macak 3 noted that in making its determination of whom to appoint as guardian and choice of residence, the court should consider the recommendations of the court-appointed attorney and the wishes of the incapacitated person, if expressed.4 “Ordinarily, once a person is declared incapacitated, the appointed guardian decides where the person will live as part of deciding what is in the ward’s best interest. [citations omitted]” However, a person who is incapacitated in some respects may nonetheless have sufficient capacity to make a choice as to where he wishes to live, and if he does, the guardianship should be limited to allow him to make the choice. [citations omitted]” These issues are ripe for mediation.

In Guardianship of Macak 7 the court further noted that “[w]here the person is not incapacitated, but he has sufficient mental or physical impairment that he requires assistance in managing his finances, he may ask the court to appoint a conservator. [citations omitted]” This choice, to which he can agree because he has capacity, does not result in the loss of his civil liberties, and he can later petition the court to remove the conservator.” 8 The conservatorship proceeding, given the capacity of the individual involved, is even more suitable for mediation of core issues such as caregiver arrangements, healthcare, financial planning, long-term care, housing and living arrangements, family dynamics, lifestyle choices, and driving.

New Jersey’s Complementary Dispute Resolution Programs

Rule 1:40 details the court rules governing New Jersey’s complementary dispute resolution (CDR) programs. Attorneys have a responsibility to become familiar with available CDR programs and inform their clients of them.9 The CDR programs include:10

Adjudicative Processes
1. Arbitration: A process by which each party/or its counsel presents its case to a neutral third party, who then renders a specific award. The parties may stipulate in advance of the arbitration that the award shall be binding. If not so stipulated, the provisions of Rule 4:21A-6 (Entry of Judgment; Trial De Novo) shall be applicable.
2. Settlement Proceedings: A process by which the parties present summaries of their respective positions to a panel of jurors, which may then issue a non-binding advisory opinion regarding liability, damages, or both.

Evaluative Processes
1. Early Neutral Evaluation (ENE): A pre-discovery process by which the attorneys, in the presence of their respective clients, present their factual and legal contentions to a neutral evaluator, who then provides an assessment of the strengths and weaknesses of each position and, if settlement does not ensue, assists in narrowing the dispute and proposing discovery guidelines.

Facilitative Process

This means and includes a process by which a mediator facilitates communication between parties in an effort to promote settlement without imposition of the mediator’s own judgment regarding the issues in dispute.

Hybrid Process
1. Mediation-Arbitration: A process by which, after an initial mediation, unresolved issues are then arbitrated.
2. Mini-Trial: A process by which the parties present their legal and factual conditions to either a panel of representatives selected by each party, or a neutral third party, or both, in an effort to define the issues in dispute and to assist settlement negotiations.

Other CDR Programs

This means and includes any other method or technique of complementary dispute resolution permitted by guideline or directive of the Supreme Court.

A ‘neutral’ is an individual who provides a CDR process. A ‘qualified neu-
How Much Does Mediation Cost?

Under Court Rule 1:40-4(a), the mediator provides the first two hours on a case without charge, which would include a first session. Thereafter, mediators will generally be paid their market rate fee (to be shared by the parties). Fees will be waived in any case covered by Rule 1:13-2(a), which provides:

(a) Waiver of Fees. Except when otherwise specifically provided by these rules, whenever any person by reason of poverty seeks relief from the payment of any fees provided for by law which are payable to any court or clerk of court including the office of the surrogate or any public officer of this State, any court upon the verified application of such person, which application may be filed without fee, may in its discretion order the payment of such fees waived. In any case in which a person is represented by a legal aid society, a Legal Services project, private counsel representing indigents in cooperation with any of the preceding entities, the Office of the Public Defender, or counsel assigned in accordance with these rules, all such fees and any charges of public officers of this State for service of process shall be waived without the necessity of a court order. Rule 1:13-2(b) provides for compensation of attorneys and states: Except as provided by any order of the court, no attorney assigned to represent a person by reason of poverty shall take or agree to take or seek to obtain from the client, payment of any fee, profit or reward for the conduct of such proceedings for office or other expenses; but no attorney shall be required to expend any personal funds in the prosecution of the cause.

What Are the Roles of Counsel and Litigants in Mediation?

Attorneys and their parties are required to make a good faith effort to cooperate with the mediator and engage in constructive dialogue regarding ways to meet client interests in a mutually acceptable settlement. Attorneys should prepare their clients prior to mediation by explaining what will happen, and the roles of attorneys and clients. They should also agree on who will be the principal spokesperson in presenting the party’s view early in the mediation session. For example, attorneys may make brief opening summaries of the issues as they see them, but clients should also be given an opportunity to speak.

When it comes to discussing terms of settlement, the litigants must play an active part, for it is their case and their settlement. During this process, attorneys should provide counsel on the advisability of settlement options, suggest options, and be available for any other consultation with their clients.

An excellent resource in the area of guardianship mediation is The Center for Social Gerontology, Inc. (TCSG). Since its inception in 1972, TCSG has been a nonprofit research, training and social policy organization dedicated to promoting the individual autonomy of older persons and advancing their well-being in society.

In the early 1990s, TCSG pioneered the use of mediation in situations where family members or friends had already petitioned for guardianship of and for an older person. TCSG’s goal was to determine if mediation might provide an alternative means of addressing the issues that were prompting the guardianship petition, particularly whether an alternative might be available that would address the issues without taking away the rights of the older person to make all or most of the decisions about his or her life. TCSG’s adult guardianship mediation program has now been used to train mediators across the country. TCSG also maintains an elder mediation annotated resource library, which is accessible at www.tcs.org/emresourcemlibrary/pdf.

Mediation Emphasis—An International Perspective

The emphasis on mediation is growing outside of the United States. In October 2007, the Adult Guardianship and Planning Statutes Amendment Act (AGPSAA) was passed in Canada. Once the AGPSAA is implemented, mandatory mediation will be required for most guardianship applications in Canada. Along with guardianship mediation, Canadian legislatures are increasingly mandating some form of mediation in disputes involving powers of attorney, caregiving and long-term care (nursing home) issues.

Conclusion

Alternative dispute resolution in probate proceedings is an excellent method for resolving probate matters. The time has come for the expansion of its use in the interests of litigants and the courts.

Endnotes


12. The rule previously provided for the first three hours to be without cost.


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Think Globally, Age Locally

New Jersey’s Global Options for Long-Term Care

by Lauren S. Marinaro

In the Oscar-nominated Disney/Pixar movie *Up®,* the elderly hero considers the possibility of residing in a nursing home and chooses a different course—tying enough helium balloons to his house (already retrofitted with a chair lift) to fly him and the house to South America. Sigh...if only. Older New Jerseyans don’t generally have that sort of ‘global’ option at their disposal. Instead, New Jersey has Global Options for Long-Term Care, (GO) a Medicaid (means-tested) waiver program for the over-65 and disabled population that provides assisted living, home-based and adult day care to those who otherwise require nursing home care.

GO, which have been in effect since Jan. 1, 2009, is really a consolidation of several previous Medicaid waivers operated by the Department of Health and Senior Services (DHSS). According to the Global Options for Long-Term Care brochure disseminated by DHSS:

Global Options for Long-Term Care (GO) is a Medicaid Waiver program for eligible seniors and adults with physical disabilities who are at risk of placement in a nursing facility but wish to receive services in the community. It can also help people currently in nursing home facilities move back into the community. GO is designed to supplement the assistance already being provided by family, friends and neighbors. GO strengthens the ability of caregivers to continue in their vital role as primary supportive providers. GO participants work with a care manager to create an individualized plan of care based on a comprehensive assessment of the participant’s healthcare needs. Once the plan of care is approved, community-based services are put in place and monitored to ensure quality and effectiveness. In certain cases, GO participants may hire their own employees.

GO participants must meet the financial criteria for the Medicaid-only program (found at N.J.A.C. 10:71 et.seq.), meaning countable resources with a value of less than $2,000 and income that is less than the 2009/2010 Medicaid-only income cap of $2,022. GO participants must meet the same clinical eligibility criteria as Medicaid applicants seeking nursing home care. This standard can be found at N.J.A.C. 8:85-2.1; but basically, the applicant must need assistance in at least three activities of daily living (ADLs). ADLs include bathing, dressing, eating, toileting, transferring, bed mobility and ambulation.

GO does not have its own regulatory handbook per se, so all of the program parameters discussed here are directly derived from the waiver document itself.

GO has three basic spheres of benefits, each in combination with case management. Within each one, a variety of benefits make up the care plan.

In-home Caregiving By Third Parties and Paid Family Members

GO plans of care are developed based on the assessed needs of the participant. Services are arranged according to the person’s choice, and availability of services and providers. A GO participant may receive up to 40 hours of home-based supportive care each week, or opt to receive the state plan personal care assistant service. Home-based supportive care can be provided by an agency or by a provider the participant chooses and the care manager approves, and can be a family caregiver as long as that individual is not the participant’s legal guardian. Attendant care, transportation and chore services are also reimbursable services under GO that can be provided by an authorized family member.

If services to meet a participant’s care needs are assessed to exceed $2,841 a month, the care manager will review the exception with his or her supervisor. When the supervisor...
assisted living confirms the need, the request will be submitted to the designated GO professional staff in the Office of Community Choice Options with a copy of the re-evaluation plan of care, written justification for the increase, and projected cost of additional services for approval and implementation (including additional hours of home-based supportive care).

The most common reasons for an increase are a change in the participant’s condition or a change in his or her informal supports. When either situation occurs, it is frequently necessary to increase waiver services to safeguard the health and welfare of the waiver participant. Since the waiver is managed in the aggregate to assure cost-neutrality, and the exact services/spending limits of each participant vary according to assessed needs, the waiver can accommodate those whose needs will exceed the spending cap. If a participant’s care needs can no longer be met under the GO waiver, and the individual’s well being is a concern, other options, including institutionalization, would then be discussed with the participant or his or her legal representative.

**Assisted Living**

When a participant moves into a licensed assisted-living facility or transitions from private pay in the assisted-living facility to Medicaid payment, the certified assisted-living administrator or registered nurse quickly initiates a plan of care. This person coordinates all services, including state plan services and services furnished through other state and federal programs. The participant’s strengths, capacities, needs, preferences, desired outcomes, health status and risk factors are considered in the plan of care. The responsible party (family member, attorney-in-fact under a power of attorney, conservator, guardian, et al), participant, and staff of the facility are included in all discussions regarding the care to be rendered to the individual, and agree to and sign the plan of care. The plan is reviewed at least monthly, and revised annually by the certified assisted-living administrator or registered nurse.

Assisted living is the only GO program where there is a cost share to the participant. The participant must have enough income to pay a shared room and board fee to the assisted-living facility of $724.05. Then, the resident is allowed to keep a $100 personal needs allowance (PNA), and may pay for supplemental insurance premiums and other outstanding medical or remedial care bills. (New Jersey contends that past-due assisted-living bills do not count as remedial care, but this issue is currently being disputed.)

If there is income remaining after these subtractions, the money must be turned over to the assisted-living facility to reduce Medicaid’s amount of reimbursement. If a participant’s income is too low to meet the minimum $824.05 in fees, the person can apply to the local Social Security office for a state supplement to bring his or her income up to the required minimum. Should family members wish to supplement the room and board so the participant can have a single room, they can do so out of their own funds.

**Adult Day Care**

Social Adult Day Care (SADC) is a GO-provided community-based group program that helps its participants remain in the community, enabling families and other caregivers to continue caring at home for an impaired family member. SADC is a structured comprehensive off-site program that provides a variety of health, social and related support services in a protective setting during any part of a day, but provides less than 24-hour care. Generally, SADC provides one meal daily. Individuals who participate in SADC attend on a planned basis during specified hours.

SADC services are provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week. Persons in assisted living are ineligible to receive SADC, as it would duplicate services.

**Other Important Services**

In addition to the above main services, in certain situations GO will pay for chore services; medical equipment and incontinence care; transportation services; respite services for caregivers; physical accessibility accommodations to the home for the participant; and one-time-only transition costs such as security deposits, utility start-up costs and furniture.

**Troubleshooting GO Applications**

**The Application Process**

Troubleshooting GO Applications

There are really two aspects to eligibility for any Medicaid program—a financial and a clinical component—and they should be handled as if on parallel tracks to assure the earliest possible eligibility date. The financial eligibility is handled by the county board of social services where the applicant resides, while the clinical eligibility is handled by the regional community choice office. Completing forms PA-4 and CP-2 (available on the DHSS website) and faxing them to the appropriate regional office should be sufficient to trigger a nurse to come out and do an evaluation of clinical eligibility. Do not wait until the client is completely spent down to obtain the clinical evaluation—it can be accomplished any time within six months or less of monies for long-term care services. If the client is applying for home-based services, or wish to transition to home-based services from a nursing home, ask to have the financial eligibility fast tracked so services in the home can be put in place as soon as possible.

**Gifts**

The state has taken the position that
Unlike nursing home applications, a person who has made gifts within the look-back period may not commence a penalty period when they are otherwise eligible, financially and clinically, for GO. However, as of April 9, 2010, the state has been enjoined from continuing with this position in the case of Fugard et al v. Velez, Commissioner. The state may appeal.

**The Income Cap**

Individuals needing nursing home care with incomes greater than $2,022 but less than the private cost of the nursing home may be eligible for Medicaid in a nursing home as a designated medically needy individual. The medically needy category, however, does not apply to a medically needy individual in home- and community-based care. There are no GO services for this medically needy population. The lawyer should take a closer look at the client’s income to determine if there is any way to disregard some income.

If the client is disabled and under 65, perhaps assignable income could be placed into a special needs trust. Doing so would eliminate that income from the client’s balance sheet in a way that would not trigger transfer penalties. If some of the income is from an annuity, the lawyer should determine if the annuity can be sold on the secondary market for a lump sum that could then be spent down to the income-cap level. If the income is from rental property, the lawyer should evaluate whether or not that property should be sold and the proceeds spent down. Social Security and pension income are non-assignable. Currently, there is federal litigation challenging whether or not disallowing a medically needy Medicaid recipient from GO violates the Americans with Disabilities Act, but there has been no ruling at this writing.

On a related note, a GO applicant may be receiving Veterans Aid and Attendance benefits. Some counties are counting these benefits as income for purposes of evaluating income eligibility for GO. This is being done in error, since Veterans Aid and Attendance benefits are not countable income for eligibility for Supplemental Security Income (SSI) benefits, and Medicaid counting rules cannot be stricter than SSI.

In determining whether or not certain other income is countable for purposes of the income cap, the attorney should not rely on the rules laid out in N.J.A.C. 10:71-5.3 regarding income exclusions. Those rules are not meant for any Medicaid program where the income cap is the SSI amount ($674) for what is called the categorically needy program, or three times the SSI amount ($674 times 3 = $2,022, which is a category known as Medicaid-only. Medically needy—where a person’s income exceeds the Medicaid-only cap—is available only to nursing home residents.

**Making Sure Assisted-living Facilities Will Accept GO**

More often than not, an assisted-living resident will transition from private pay to GO after a significant spend down of funds. It is important to know when the resident moves to his or her assisted-living facility that they will not be evicted for achieving GO eligibility at the end of the spend-down period. Make sure the assisted-living facility provides their written Medicaid policy disclosure statement regarding any mandatory spend down or other GO-related policy when the resident first moves in, and continue to advocate for the client with the facility for eventual GO acceptance.

Further, an assisted-living facility that may not wish to take a Medicaid-eligible individual may reconsider if a family member is willing to pay supplementation, or the fee that upgrades the resident from a shared room to a private room or studio.

It is important to have a candid discussion with the assisted-living facility well in advance of any possible Medicaid eligibility.

**Ways to Pay for Extra Caregiving**

One complaint of the GO program is that outside of the assisted-living setting, where there is generally some staff available in a crisis at all times, there are no 24-hour-a-day supports for caregivers, and that at the most, the basic benefit in the community will be 40 hours a week of health aide care, with occasional respite. The GO waiver is fairly clear that GO was never designed to be a “nursing home at home,” but was instead designed to support community caregiving of family and friends. However, an applicant must require a “nursing home level of care” to participate. That might mean looking to some other source of funds for additional caregiving. If the applicant is married, those funds might be the spouse’s allowed assets and/or income.

Another possibility would be to take out a reverse mortgage on the home where the care is being received by the GO enrollee. (This must be approached with care, particularly where there are litigious prospective heirs interesting in inheriting the home.) Under the SSI rules, loan proceeds are not considered a resource to the borrower or income to the borrower. So a reverse mortgage, which typically requires no repayment until the borrower passes away or permanently leaves the residence, can be a good source of supplemental funds for in-home caregiving while that person is receiving GO services.

**Advocating for the Most Services for Your Client**

Post-eligibility, if the participant is receiving services in a home setting, there will be further evaluation of exactly what amount and type of services the participant needs. Most of the time,
the services cannot exceed 40 hours per week. If there are family supports already in place, the hours may be even further reduced, though there is nothing in the GO waiver that lays out the circumstances that would lead to fewer than 40 hours of attendant care or home-based supportive care. If a GO recipient, or his or her representative, thinks he or she is being short-changed on the number of hours of services, recourse may be sought through a fair hearing before an administrative law judge.

GO, like Medicaid generally, provides important benefits that may be challenging to navigate and utilize. Elder law attorneys should use their skill to advocate for clients who wish to ‘age in place’ using those benefits.

Endnotes

4. New Jersey Department of Human Services et al. (unpublished, on file with author).
8. See N.J.A.C. 10:71-5.6(c)(5) and (d)(5).
9. See POMS SI 01140.300.E.3
10. See http://www.state.nj.us/health/forms/ltc-32.pdf, the needs-based allocation tool.

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Elder Law’s New Frontier—VA Benefits

by Robert F. Brogan

“To care for him who shall have borne the battle and his widow and his orphan.”

ABRAHAM LINCOLN
(in his second inaugural address)

The motto of the U.S. Department of Veterans Affairs (VA) quoted above reflects the goals and objectives of today’s elder law attorneys in their daily practice. As was appropriate for his time, President Lincoln alluded to a wounded man, but today’s military includes veterans of both sexes. They are men and women who have dutifully served the United States. These veterans, along with their spouses and their dependent children, face difficulties the elder law practitioner is perfectly suited to address.

Just as special needs planning has become an ancillary practice for most elder law attorneys, it appears that a working knowledge of veteran’s benefits will be a basic requirement for those who want to call themselves elder law attorneys. Elder law is, by nature, a holistic practice. It is time that the practice area expand to include an analysis of whether veteran’s benefits can help clients achieve their goals.

Even those who do not practice elder or special needs law will have clients who have served, and who may be entitled to veteran’s pension or compensation. These practitioners need to be aware of the situations that give rise to potential medical coverage or financial assistance from the Department of Veterans Affairs (VA). They need to know the benefits may extend from a deceased veteran to the surviving spouse or disabled child. Having a base knowledge of the key issues, they will then be able to guide that client to a practitioner who can pursue the client’s claims for benefits.

VA benefits can complement various long-term care asset protection strategies. This article’s objective is to guide the practitioner who may be aware that the VA offers certain services beneficial to their clients, but does not know what benefits may be available. Further, it is to sound the clarion call that attorneys practicing elder law need to educate themselves about these benefits.

A Little History and Background

Going back to the time of the American Revolution, Congress has sought to provide for injured soldiers. The costs involved in doing so following World War I had so drained the budget that benefits were being greatly reduced. A march by veterans on Washington touched the hearts of Americans, and by many accounts was the catalyst for the creation of the present system.

Under the present system, after reviewing a completed application for health benefits (Form 10-10ez), the VA will determine whether an applicant qualifies as a veteran and place the veteran in one of eight categories of status. The categories are based on such criteria as the percentage of disability, whether the veteran was a prisoner of war, or whether the veteran received a Purple Heart. A veteran’s category dictates what medical coverage or services he or she will be entitled to, and the veteran’s priority for slots for such services.

Senior veterans in the less severe categories may still find it advantageous to qualify for VA benefits, particularly if they take pharmaceutical medications. There may be co-pays, but the VA can provide better coverage than Medicare Part-D plans. The veteran may also qualify for medical care in a VA hospital or medical center.

Nursing Home Care—All VA Homes are Not Created Equal

If it is determined that a veteran has a 70-percent service-connected (SC) disability, then he or she is entitled to care in a VA nursing home. For an attorney holding him or herself out as one who is able to guide clients through the labyrinth of asset preservation, knowing there is a potential way to get 100 percent coverage for long-term skilled nursing care is essential. Unfortunately, that care may need to be provided out-of-state, at a facility owned and operated by the VA.

There are different types of nursing homes supported by the VA. In New Jersey, the three military facilities are not owned by the federal VA but by the state of New Jersey’s
Department of Military and Veteran’s Affairs. The VA principally funds the federal facilities directly. In most state military facilities, Medicaid funds their long-term beds, and both financial and medical criteria are imposed. 3

The VA does operate several outpatient medical centers, which offer a variety of services. Pharmaceuticals, pain management, physical examinations and other services can be provided at these centers, but they are not designed to provide long-term skilled nursing. For veterans who are taking expensive ongoing medications, these outpatient service centers can save hundreds of dollars on their pharmaceutical bills annually. The services provided there can be a vital piece of a plan to maintain independence in the community rather than move to a long-term care facility.

A Note of Caution

Due to the drastic differences between how Medicaid and the VA look at asset transfers, practitioners new to VA planning must be extremely careful. Always caution clients regarding the impact of any transfers under both criteria. If the client undertakes a divestment plan anticipating immediate VA coverage, but then needs to apply for Medicaid, Medicaid is still going to penalize those transfers under its own rules. 4 The impact of a period of ineligibility could be devastating if a client needs to move immediately and a bed in a VA facility will not be available for six months. Fully informed disclosure is crucial.

Pension Benefits

In addition to the variety of covered medical care, there are two distinct monetary benefits paid by the VA: pension and compensation. 5 Pension benefits can be very useful for clients. The three categories of pension benefits are: 1) improved pension; 2) homebound; and 3) aid and attendance. A VA Form 21-526 is completed to apply for any of these benefits.

While a veteran cannot receive both pension and compensation benefits simultaneously, the VA will determine which benefit would generate the highest monthly payment to the veteran and approve the higher figure as the monthly amount to be paid.

Pension is an income paid to a veteran who served at least one day in wartime, received a discharge other than dishonorable, and demonstrates a financial need as well as some level of disability. The disability does not need to be related to military service. A client under the age of 65 can be determined to be disabled based on a sliding percentage scale. Notably, simply being over the age of 65 qualifies a veteran as being ‘disabled’ for purposes of satisfying the disability criteria. The majority of veterans who seek legal assistance fall into that category.

Though there is not a specific resource limit, the VA does look at the veteran’s net worth assets to determine financial income eligibility. 6 Net worth assets are bank accounts, stocks, bonds, mutual funds, IRAs, and any property other than the veteran’s residence and a reasonable lot area. Income includes earnings, disability and retirement payments, interest and dividends, and net income from farming or business received by the veteran and his or her dependents. The VA is looking at net worth assets to calculate the amount of income the veteran will generate based on the return on investment of the assets over his or her lifetime.

Financial eligibility is directly related to the healthcare cost to that particular applicant. In establishing eligibility for pension, a veteran may deduct from his or her monthly income a portion of unreimbursed medical expenses, as long as he or she is not going to be reimbursed for those expenses by private insurance or Medicare. If those medical expenses exceed five percent of the maximum annual pension rate (MAPR) established by the VA, they are deducted from the amount of gross monthly household income for purposes of determining the amount of annual pension benefit to be paid to the veteran. Applying that deduction, many veterans of World War II, Korea, and Vietnam, who appear initially on paper to make more than the MAPR, will still qualify for the VA pension benefit. 7

Also, pension benefits and health coverage may be available to the widow or widower of a qualifying veteran. Except for certain unique circumstances, such as the recent caregiver spouse’s coverage for Iraq and Afghanistan veterans, most VA benefits are not available to the spouse while the veteran is living. 8 Some death benefits can provide health coverage through the Civilian Health & Medical Program of VA (CHAMPVA) for those spouses and disabled children of veterans who meet certain criteria at the time of the veteran’s death.

Aid and attendance is perhaps the VA benefit most frequently discussed in elder law circles. Aid and attendance is a pension benefit of financial assistance for veterans who have established financial and medical eligibility for assistance. 9 The medical criteria are that the veteran must be so helpless he or she requires the aid of another person to perform the functions of everyday living. This is analogous to the clinical or medical criteria concerning activities of daily living for Medicaid eligibility.

Aid and attendance is only one of the three types of pension benefits. The two other types of pension benefits are homebound pension and basic improved pension. The aid and attendance requires the highest disability and need for assistance with basic improved pension requiring the least. The rates vary accordingly based on which level of disability the veteran demonstrates. The attorney must analyze all the potential benefits for a particular client before determining which is most appropriate and favorable for him or her.
The compensation and pension benefits can be valuable tools to maintain an eligible veteran in his or her home, or perhaps in an assisted-living setting, to avoid transition to a skilled nursing facility. Like the objectives set out in the Olmstead decision, the VA benefits can further the goal of providing care in the least restrictive environment while maintaining the dignity and independence of someone in need of medical and financial assistance. 10

An Example of How Pension Benefits Can Help Seniors

Assume there is an elderly veteran who has hired a licensed live-in aide provided by a home care company. These medical costs deducted from his or her income can qualify the veteran for pension benefits. If a veteran, who satisfies the service and disability criteria, makes more than the MAPR, he or she can use the $4,000 per month the veteran is paying to the home care company as a deduction of $48,000 from his or her annual income. If his or her regular annual income was $50,000, for VA purposes that income would be treated as $2,000 annually, taking into account the home care expense. Under New Jersey’s Community Medicaid income cap, the veteran would be barred from being eligible for Medicaid coverage. 11 For VA purposes, however, if that outlay for medical costs brings his or her income below the rate thresholds, he or she is entitled to receive as pension the difference between the adjusted net income and the MAPR.

Compensation Benefits

Compensation benefits, similar to Worker’s Compensation, are payments made to veterans or their surviving dependents for a condition that was incurred during, or aggravated by an occurrence in the line of duty.

Notably, “in the line of duty” is a term of art, one of many the VA utilizes. The language of the VA can be confusing for attorneys new to the field. Many of the words can be the same as other legal terms of art familiar to attorneys, but in the VA the terms mean something entirely different. “In the line of duty” means an injury incurred at any point during a veteran’s service period, and is not limited to the time he or she is in a field of combat. 12

A veteran who enlisted after Sept. 7, 1980, must establish two initial criteria. The veteran must have served one day during wartime as established by Congress or presidential decree. He or she must have served at least 24 months or the full period for which he or she was called or ordered to active duty. Prior to that Sept. 7, 1980, date, veterans who served at least one day during war time and served 90 days of active duty are eligible. In fact, as long as their service falls within that criteria, they did not need to be in a field of combat in order for the injury to be compensable. For example, an injury during training that occurred while stationed on a base in the United States may be covered.

Lastly, the reason for discharge could not have been dishonorable. 13

The system for qualifying for compensation benefits is extremely slow. Congress has called the VA to task several times with various hearings seeking to improve the wait time for decisions and appeals, which can often take years to be resolved.

There are special categories of illness and physical conditions that are automatically compensable under VA criteria. For example, there is coverage for certain conditions like Parkinson’s, and certain cancers linked to exposure to Agent Orange are automatically covered. There is coverage extended to the children of female veterans who conceived after Vietnam, who developed certain birth defects resulting in permanent physical or mental disability.

There are other injuries, which if diagnosed properly would be compensable, but may be difficult to diagnose.

The number of veterans who suffered traumatic brain injury in Iraq and Afghanistan, for example, is difficult to track. Apparently, a majority of veterans suffering traumatic brain injuries do not have outwardly noticeable injuries following the concussive effects of being near a blast. Many may not have even reported anything to their commanders at the time of the injury, making it potentially difficult to document the disability later for purposes of applying for compensation. 14

How Much May the Veteran Get Paid?

If approved for pension benefits, the MAPR for aid and attendance for a veteran with a spouse and no other dependents is $23,396. If single without dependents, the MAPR is $19,736. The rates for homebound benefits is $18,120 with one dependant, and $14,457 without a dependant. The basic improved pension rates are much lower, at $15,493 with a dependent spouse or $11,830 without a spouse. The totals change depending on how many dependants the veteran has. The rates for 2010 are the same as in 2009, as there was no cost of living adjustment this year.

If approved for compensation benefits, the payment is based on the percentage of disability as established by the VA. The benefits start very low, but increase for those seriously injured. For example, a veteran with 10 percent disability gets $123 a month. With a 20 percent disability, he or she gets $243. On the other end of the spectrum, for single veterans who have greater than a 70 percent disability the monthly benefit is $2,673. If married, the benefit is $2,823. Therefore, advocacy to insure that the proper disability rating is applied becomes vitally important to the veteran and his or her spouse.

Attorneys are Relatively New to the Process

Traditionally, the primary advocates
for veterans seeking compensation or pension benefits have been Veterans’ Service Organizations (VSOs). These groups have been permitted by statute and regulation to assist veterans to complete the paperwork necessary to file a claim and, to some extent, with subsequent appeals of adverse decisions. Until recently, attorneys could not receive any payment for assisting veterans denied benefits, so the VSOs served that advocacy role. By most accounts, for decades they have done so admirably.

However, with the appeals process getting more complicated, and a mechanism now in place to have fees paid, veterans are more likely to start seeking the assistance of accredited counsel. Particularly for compensable benefits, it may become routine for the VSOs to continue assisting with the initial application and accredited attorneys will be involved following initial denials or to appeal the percentages set by the VA.

Under 38 U.S.C. Section 5904(c), veterans cannot hire an attorney for a VA proceeding until the Board of Veterans’ Appeals (BVA) issues a final decision. This is a crucial point. An attorney may not charge a veteran for making an application on his or her behalf. If an attorney is accredited, the limitation against payment means he or she cannot get paid until after there has been a denial. If there has been a denial, and the attorney successfully represents the veteran in the appeal, then counsel fees are permitted from a percentage of the benefit award. The retainer entered into between the veteran and counsel must state at the outset whether the attorney will be paid directly by the veteran or from the award.

Accreditation: A Prerequisite to Helping a Veteran

An attorney cannot assist in the completion of an application on behalf of the veteran unless he or she is accredited as an attorney by the VA, or is working in an approved VSO. Attorney accreditation requires submission to the VA of a completed Form 21a, which includes naming three other attorneys who can attest to the individual’s qualifications as an attorney. Assuming the attorney’s good-character check is approved internally, a letter of accreditation will be received about 30 days after submitting the VA Form 21a. Within one year of receipt of that letter, the attorney will be obligated to attend a three-hour course from an approved provider. The course is specifically tailored to educate the attorney on appearing before the VA, and goes into great detail regarding what services are compensable and what are not.

There are subsequent continuing legal education requirements in the following years, and there are an increasing number of VA benefits seminars being offered by various providers. Following accreditation, it is up to the practitioner to delve into this valuable practice area and develop their expertise.

Endnotes

1. For an excellent treatise summary of the subject matter, see William F. Fox Jr., The Law of Veterans Benefits: Judicial Interpretation (3d ed., Paralyzed Veterans of America, 2002).
6. VA Claims Adjudication Manual M21-1MR, Part V, Subpart iii, Chapter 1, Section J.
7. By comparison, for community waiver benefits Medicaid factors the gross income of the applicant without deducting any of the incurred medical costs.
13. 38 C.F.R. §3.12, and 38 C.F.R. §3.13.

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Elder law attorneys are frequently asked to file an application for Medicaid benefits on behalf of a client. They also may engage in Medicaid planning for the client, the process through which an attorney attempts to shelter a portion of the client’s assets for either his or her family’s benefit and qualify for Medicaid sooner than he or she would qualify without planning.

As New Jersey’s state budget gets tighter and tighter, due to more demands on the system and less revenue coming in, the Division of Medical Assistance and Health Services (DMAHS), which administers the Medicaid program in New Jersey, seeks to curtail common Medicaid planning techniques. Increasingly, the state has sought to curtail Medicaid planning through a series of unwritten policy directives. New Jersey last issued written regulations implementing the Medicaid program in June 2001.

In New Jersey, DMAHS administers the Medicaid program, and it contracts with the local county boards of social services (CBOSS or board) to process applications for benefits.

In February 2006, Congress passed and the president signed into law an omnibus budget bill that, in part, toughened the Medicaid transfer of asset rules. This law, known as the Deficit Reduction Act of 2005 (DRA), brought what many in state government believed to be the death knell for common Medicaid planning techniques; however, as time passed, the state began to see an increasing number of new techniques it did not anticipate, or want, after the passage of the DRA.

Historically, when an application for benefits is denied or when the anticipated eligibility date is not achieved, elder law attorneys represent their clients through a state administrative appeals process called a fair hearing. The CBOSS will issue a denial of benefits notice. If the applicant chooses to appeal the denial, he or she must file for a fair hearing within 20 days of the date of the fair hearing notice.

A fair hearing is conducted before an administrative law judge (ALJ), employed by the Office of Administrative Law, an independent executive branch agency. A fair hearing involves the presentation of legal argument and facts, through the submission of documents and testimony. It is a formal proceeding, but the rules of evidence are more relaxed than an attorney would experience in the superior court. The burden of proof is on the applicant, and the standard is a preponderance of the evidence.

After the actual hearing, the ALJ has 45 days to render an initial agency decision; however, the ALJ’s decision is merely a recommendation to the director of DMAHS. Within 45 days of the initial decision, the director may adopt, modify, or reject the ALJ’s decision.

If an applicant for benefits is dissatisfied with the director’s decision, he or she has the right to appeal to the Appellate Division, but on appeal, the applicant must prove the director’s decision was arbitrary and capricious.

The Medicaid Act is a federal law. The act is quite comprehensive, and while states are permitted some leeway in implementing the law (Medicaid programs often vary from state to state), the state must comply with certain hard-and-fast requirements. If a state fails to comply with the act, a claim involving a federal question is implicated.

There are two primary avenues to federal court—diversity jurisdiction and federal question jurisdiction. Briefly, diversity jurisdiction exists when the matter in controversy exceeds $75,000, and the suit is between citizens of different states. Federal question jurisdiction exists over matters that raise federal questions, that is, actions that arise under the United States Constitution or federal statutes/acts, such as the Medicaid Act. The bases for the “right” to sue, as opposed to the substantive aspects of the suit, are the supremacy clause of the United States Constitution and 42 U.S.C.A. Section 1983.

There must be an individual who is violating a federal law in order for a right to sue to exist under Section 1983. For this reason, in the cases under discussion here, a plaintiff in a federal court is suing the head of the administrative agency that is failing to comply with the Medicaid Act, and is not suing the state of New Jersey. Typically, in a federal lawsuit implicating a Medicaid issue, the suit is filed against the director of DMAHS, in his or her official capacity, and against his or her boss, the commissioner of the New Jersey Department of Medicaid Issues in Federal Court

by John W. Callinan

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Human Services, in his or her official capacity.

The first question to ask when deciding either to file for a fair hearing or to file a federal action with regard to the denial of Medicaid benefits is: Do I have a federal question? The next most important question to ask is: Can I get the relief that I seek in federal court? The 11th Amendment to the United States Constitution generally protects the states against money awards, but 42 U.S.C.A. Section 1396a(a)(34) permits a three-month retroactive award of Medicaid benefits. A federal judge can, therefore, order injunctive relief, but can only order federal defendants to award Medicaid benefits three months retroactively. While the boards have an obligation to process an application for Medicaid benefits within 30 days of the application being filed (this is called the “promptness requirement”) the county boards fail to fulfill this obligation on a regular basis.

Many boards take four months to over a year to process an application. Not only does this violate the act’s promptness requirement, putting the state out of compliance with the act, it also harms the applicant’s opportunity to sue the state in federal court.

For instance, if a client files an application on March 1, 2010, and finds out on Feb. 1, 2011, that the CBOSS is going to deny his or her application for a reason the attorney believes violates the federal Medicaid Act, the client would have to forego many months of Medicaid benefits if he or she sued in federal court, assuming that he or she won. The federal court will only be able to enjoin the director to award benefits three months retroactively from the date of the first court order, which might be entered several months after the filing of the federal complaint.

Below, is an example of how a plaintiff might get the quickest result in federal court when the state’s policy is known in advance of the filing of an application for benefits.

After the attorney files a complaint in federal court, the state will likely file a motion to dismiss the complaint in lieu of an answer, claiming the plaintiff should not be in federal court at all. The state typically makes arguments under the Younger abstention doctrine, the Blessing-Freestone doctrine, and the Rooker-Feldman doctrine. In many instances, each of these arguments is inapplicable and can easily be overcome.

Exhaustion of state administrative remedies is not a prerequisite to filing an action in federal court. In other words, a proposed federal plaintiff does not have to go through the state’s fair hearing process before he or she can file a lawsuit in federal court. The Younger abstention doctrine is somewhat akin to the concept of exhaustion.

The Younger doctrine has three parts—there must be the existence of an on-going state proceeding that is judicial in nature, the implication of important state interests, and an adequate opportunity to raise constitutional challenges in the state proceeding. The state typically argues that the opportunity for a fair hearing is the “on-going state proceeding,” that Medicaid is an important state interest, and that the aggrieved applicant can raise constitutional challenges in the context of a fair hearing. Note that the mere existence of the opportunity to take a fair hearing, not the actual existence of an on-going fair hearing, is what the state argues is the “on-going state proceeding.”

But here’s the rub, the Younger doctrine only applies to state administrative proceedings that are coercive in nature, not those that are remedial in nature. For instance, an administrative proceeding involving the issuance of fines for parking violations would be coercive in nature. On the other hand, an administrative proceeding to remedy the wrongful denial of Medicaid benefits, that is, a fair hearing, is remedial in nature. An applicant for Medicaid benefits does not have to file for a fair hearing in order for the state to assess a penalty period against him or her for an uncompensated transfer of an asset.

If the applicant takes a fair hearing, he or she is merely trying to remedy a perceived injustice. The fair hearing is not something the state has initiated against the applicant to coerce his or her conduct in a manner the state deems acceptable. The Younger doctrine applies only to state proceedings that are coercive in nature, not to those that are remedial in nature. So, notwithstanding the opportunity for a fair hearing, the Younger doctrine does not prohibit the institution of a federal lawsuit.

In Dultz v. Velez, docket 09-1049, a case dealing with transfer of asset penalties in the context of Medicaid waiver programs, the Hon. Freda L. Wolfson, U.S.D.J., denied the state’s motion to dismiss based upon the Younger doctrine. This matter is currently pending a decision on the plaintiff’s motion for preliminary injunction.

The Blessing-Freestone doctrine provides that a right of action under 42 U.S.C. Section 1983 only exists if the substantive federal statute in question (for instance, a statutory section of the Medicaid Act) satisfies three criteria. The federal statute must unambiguously impose an obligation on the state. The right imposed cannot be vague and amorphous so that its enforcement would strain judicial competence. And, Congress must have intended the law to benefit the plaintiff; that is, the statute must contain “rights-creating” language.

Without getting into too much detail, many provisions of the Medicaid Act do meet the Blessing-Freestone test; however, the attorney must ensure that the statute has rights-creating language for the plaintiff. Does it speak in terms
of the person benefited, or merely a class of benefited people? The former passes the Blessing test; the latter does not.

If the provision of the act satisfies the rights-creating language prong of the Blessing test, the statute would, in all likelihood, satisfy the other two requirements of the test.

However, even if the plaintiff fails the Blessing test, he or she may still be able to proceed in federal court under the supremacy clause of the United States Constitution since the state’s action in failing to comply with the Medicaid Act violates that provision of the Constitution. However, unlike a Section 1983 action in which attorney’s fees are available, the prevailing party in an action brought under the supremacy clause is not awarded attorney’s fees.

Finally, the Rooker-Feldman doctrine holds that if there has been a state court adjudication of an issue with regard to the proposed federal plaintiff, the plaintiff is barred from attacking that state court judgment in federal court. The Rooker-Feldman doctrine does not, however, apply to state administrative actions, so even if the plaintiff took a fair hearing and received a final agency decision from the director, he or she would not be barred from attacking that final agency decision in federal court. The final decision would, in essence, be the state’s policy.

**Getting a Quick Result in Federal Court**

So, how is a quick result obtained in federal court? First of all, ensure that the question being presented to the court is a question of law, not fact. For instance, can an annuity be treated as a countable resource without violating the Medicaid Act’s comparability provision? Can a state assess a penalty of unlimited duration against an applicant for Medicaid waiver services without violating the transfer of asset rules? These are legal questions, not factual questions.

Secondly, the complaint should be filed and served upon the department head, the director, and the attorney general by personal service. Immediately after the complaint is served, a motion for preliminary injunction should be filed. This will get the case into court within a month of having filed the complaint.

A preliminary injunction will issue only if the plaintiff can prove he or she will win on the following four elements: 1) the likelihood of success on the merits, 2) irreparable harm to the plaintiff if an injunction does not issue, 3) any irreparable harm defendants will suffer if the injunction issues, and 4) the consideration of the public interest.

Take the annuity issue as an example. Under federal law, an annuity is an income item to the owner, not a resource item. The state of New Jersey seeks to treat an annuity as a resource item, not an income item.

For this reason, the filing of a federal lawsuit may be necessary when it is anticipated that the state will implement its policy that violates the federal Medicaid Act. The suit may be filed several weeks after the initial application is filed with the CBOSS, claiming that by the time the motion for preliminary injunction is heard, the state will have failed to comply with the promptness requirement, and that the policy of the state in treating an annuity as a resource item is known and violates the Medicaid Act.

When one member of a married couple applies for Medicaid, the spouse in the nursing home is known as the institutionalized spouse and the spouse living at home is called the community spouse. When the institutionalized spouse applies for Medicaid, the resources of both spouses are pooled, so whatever resource one spouse owns, the other spouse owns.

The community spouse is permitted to retain certain non-countable resources—such as the house, a car, personal goods and household effects—and a certain amount of countable resources—such as bank accounts, stocks. The countable resources the community spouse can retain are called the community spouse resource allowance (CSRA). Currently, the maximum CSRA is $109,560 and the minimum is $21,912.

Assume that Mr. Smith applies for Medicaid and he is married to Mrs. Smith. Mr. and Mrs. Smith own a home, a car, and $200,000 in cash. The CBOSS would tell Mrs. Smith that she can retain the home, the car, and $100,000 (or one-half) of the cash, which is a countable resource, as her CSRA

Mrs. Smith contacts an elder law attorney, who suggests she purchase a single-premium, actuarially sound, immediate annuity that names the state of New Jersey as first remainder beneficiary and her children as secondary beneficiaries. The purchase of this type of annuity converts the Smiths’ excess resources of $100,000 into a stream of income that belongs only to Mrs. Smith. Unlike resources, which are pooled, income belongs to the spouse whose name appears on the check. By purchasing the annuity, Mrs. Smith can now retain what was $100,000 in resource and what is now a stream of income payments to her.

At least this is what the federal law permits, and two recent decisions of the United States Court of Appeals for the Third Circuit (James v. Richman and Weatherbee v. Richman) tell us that is correct. But in New Jersey, a recent decision of the Appellate Division, N.M. v. DMAHS, would appear to cast doubt on these decisions and caution against the purchase of such an annuity.

So, what is an elder law attorney to do? Waiting for the CBOSS to make a decision on the application may leave
the attorney without the option of purs-
ing the claim in federal court from a practical standpoint, because of the client’s need for what are now retroac-
tive benefits. The author believes a viable strategy is to file an action in fed-
eral court after an application for Medi-
caid benefits has been filed with the CBOSS, because the client knows what the state’s policy is with regard to annu-
ties. And, since the client has a current application for Medicaid benefits pend-
ing, he or she has a right to enjoin that policy.

The state may attempt to treat the annuity as a countable resource, relying on the holding in N.M., yet in federal court, relying on the holdings in James and Weatherbee, the DRA and other pro-
visions of the Medicaid Act, the attorney may prevail on the issue.

Conclusion

The federal courts offer elder law practitioners a very nice alternative for litigating issues that implicate the federal Medicaid Act. In the state fair hearing process, the director of the DMAHS can reverse a successful appeal to an ALJ. In federal court, on the other hand, the judge has the final say. Unlike the state court system where the director’s decision is entitled to deference, in federal court the director’s position is merely the position of an opposing party enti-
tled to no deference at all. 

Endnotes

2. See generally N.J.A.C. 1:1-1.1. et seq. (stating the rules governing the fair hearing process).
5. See, e.g., 42 U.S.C.A. § 1396a (outlining mandatory requirements with which a state’s Medicaid plan must comply).
8. U.S. Const., art. VI, cl. 2.
9. See generally, Morenz v. Wilson-Coker, 415 F.3d 230 (2d Cir. 2005) (discussing an award under the Medi-
caid Act and the limitations of the 11th Amendment).
17. 42 U.S.C.A. § 1396n.
19. 42 U.S.C.A. §§ 1396a(a)(10)(C) (i)(III) and 1396a(r)(2)(A) (known as the “comparability provisions” of the Medicaid Act).
26. 42 U.S.C.A. § 1396p(c)(1)(F) and (G) (discussing the requirements of an annuity in the context of the Medi-
caid transfer of asset rules).
27. 42 U.S.C.A. § 1396r-5(b).

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Many older New Jerseyans seek legal counsel for problems they share with their younger counterparts, for problems indigenous to them because of their age, and for problems exacerbated by age. Fortunately, older adults turn out in local and statewide elections at a higher percentage rate than the rest of the population, so legislators eagerly respond to the appeals by older constituents for statutory remedies. As a result, there are now protections for the clients who used their nest eggs to purchase an annuity from a predator; for the clients victimized by egregious medical errors in hospitals; for the clients who find it difficult to navigate the application process for needed entitlements; for the ailing boomer who finds relief from pain in medical marijuana; and for a host of other rights accorded them by New Jersey government.

This article provides an update on a broad range of enactments during the past two years, enhancing the quality of life of many clients—from financial planning and consumer fraud protections to measures reinforcing healthcare standards and bolstering physical safety and well-being.

Health, Safety, and Physical Well-Being

Safety First
The Silver Alert System

The Silver Alert System is a statewide program to be established by and administered through the Attorney General’s Office. Its purpose is to enhance law enforcement efforts in the recovery of missing persons suffering from dementia or other cognitive impairments. Through voluntary, collaborative action between the media and local and state law enforcement agencies, pertinent information about the missing person will be rapidly disseminated to the public.

Before a silver alert may be issued, five criteria must be met: 1) it is believed the missing person is “suffering from dementia or other cognitive impairment[,] regardless of age;” 2) the local law enforcement agency for the area in which the person went missing has the missing persons report; 3) it is believed the missing person is in danger of serious bodily harm or death; 4) there is enough information available on the missing person to ensure that issuing a silver alert will be helpful in finding the person; and 5) sufficient information can be made available to the public to help locate the person.

Specific health information about the missing person, however, is not to be made public through any means. In the event of an alert, the local law enforcement agency that first received the missing persons report will be the lead agency with responsibility for communications to the media and various other government agencies involved in assisting.

Defibrillators are Not Just for Nursing Homes Anymore

Under this newly expanded law, assisted-living facilities are now required to procure and maintain at least one defibrillator at their facility (prior to this amendment, the on-premises defibrillator requirement applied only to nursing homes). This life-saving device must be stored in a central location within the facility, and the location must be known to all employees. Additionally, the assisted-living facility must provide training to all employees in the use of the defibrillator and in cardio-pulmonary resuscitation. The facility must also notify all appropriate emergency medical personnel of the type and location of the defibrillator. Assisted-living facilities had until April 23, 2010, to bring their institutions into compliance with this patient safety-minded law.

Health and Drugs
Rx Help is on a Roll—Auto-Enroll

This new law establishing “automatic enrollment” for eligible program recipients creates a more seamless interchange
between two distinct but closely linked prescription drug assistance programs in New Jersey: the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program, and the Senior Gold Prescription Discount Program. While each program helps low-income individuals gain access to needed prescription drugs, each has different income eligibility requirements.

Under this updated process, anyone enrolled in the PAAD program who becomes ineligible due to increased income will automatically be enrolled in the Senior Gold program (provided the income increase is within the eligibility requirements of that program). Conversely, anyone enrolled in the Senior Gold program whose income decreases will automatically be enrolled in the PAAD program. With one uniform application, each program has access to all of the information required to determine an applicant’s eligibility for either program, thus enabling transfer between programs as necessary.

Through the automatic enrollment system, these programs can respond to and accommodate fluctuating financial circumstances of enrollees while continuing to provide them with the prescription drug assistance they need. A copy of the uniform application may be accessed online at www.state.nj.us/health/forms/ap-2.pdf.

New Jersey Compassionate Use Medical Marijuana Act

This act provides for the legal use of marijuana by patients with debilitating medical conditions that are unresponsive to conventional or other therapies. It also protects their physicians, caregivers and those who are licensed and registered to provide marijuana for medical use. Qualified medical conditions include: seizure disorders such as epilepsy; intractable skeletal muscular spasticity; and glaucoma. Also, conditions with associated severe chronic pain, nausea and vomiting, emaciation or “wasting,” such as: cancer; HIV or AIDS; amyotrophic lateral sclerosis; multiple sclerosis; terminal cancer; muscular dystrophy; inflammatory bowel disease, including Crohn’s disease; and terminal illness (doctor’s prognosis is less than 12 months of life).

To qualify for legal use of medical marijuana, a patient’s condition must be certified by his or her treating physician, and the physician must give specific authorization for the patient to apply for registration for medical marijuana use. The patient, and caregiver, if applicable, is issued a registry identification card that is valid for two years.

Other Drug-related Points of Interest

Drug labeling of consumer prescriptions by pharmacies has taken a slightly new form as of Jan. 27, 2010. Prescriptions filled with a generic drug instead of the branded medication must denote both drug names on the prescription label. The information is to be specified in the following manner: “_____ Generic for _____.”

Another pharmacy mandate, though not entirely new, is even more worthy of mention because of its benefit to consumers: the New Jersey Prescription Drug Retail Price Registry Act. On a weekly basis, the director of the Division of Consumer Affairs, in conjunction with the commissioner of Human Services and Health and Senior Services, collects and compiles retail drug pricing information provided by licensed pharmacies. The information is made available (both in English and Spanish) to the public via the Internet in an interactive format so consumers can comparison-shop retail drug prices among local pharmacies. The information is also made available by phone (toll-free).

The prescription drug registry may be accessed at https://www6.state.nj.us/LPSCA_DRUG/index.jsp.

Health Issues in Healthcare Institutions and Facilities

Hospitals Get Specific

The Department of Health and Senior Services (DHSS) now is mandated to collect hospital-specific data concerning 14 separate patient safety indicators for inclusion in its annual New Jersey Hospital Performance Report. The DHSS commissioner may include additional indicators in the report, such as those recommended by the Centers for Medicare or Medicaid Services (CMS) or the federal Agency for Healthcare Research and Quality, among others. Additionally, after conducting a study the Quality Improvement Advisory Committee (QIAC) will make recommendations to the health commissioner about expanding public reporting by the DHSS of the following issues: pressure ulcers, infections due to hospital care, and falls occurring in hospitals.

A hospital cannot seek payment from a patient or a third party for any of the following hospital-acquired conditions or events: transfusion reaction; air embolism; foreign body left during the procedure; surgery on the wrong side, wrong body part, wrong person, or wrong surgery altogether performed on a patient.

Ambulatory Surgical Centers Get Tracking…or Sent Packing

Beginning July 1, 2011, when billing for healthcare services, ambulatory surgical centers will have to use a common billing form for each patient, as designated by the health commissioner. To the extent possible, ambulatory surgical centers will provide the same type of information on the billing forms that hospitals are required to provide. Also, the physician identification numbers appearing on hospital or ambulatory surgical center billing forms will be made publicly available, provided the manner of doing so complies with Healthcare Insurance Portability and
Accountability Act of 1996 (HIPAA) guidelines.\textsuperscript{35}

Under this law, ambulatory care facilities will furnish quarterly reports to DHSS regarding infection control processes and procedures that impact patient safety and care.\textsuperscript{36} The reports must include data on multiple measures of infection rates, as designated by the commissioner and the department’s QIAC.\textsuperscript{37}

If the commissioner identifies a problem based on the information provided in the reports, the ambulatory care facility will receive prompt notice that a change in policy or practice is needed to improve the facility’s performance in delivering quality care and preventing infection.\textsuperscript{38} As with hospital reporting, information on infection rates and other quality-of-care measures reported quarterly by ambulatory care facilities to the DHSS will be made available to the public on the DHSS website.\textsuperscript{39} The data will be presented in a format that enables the public to draw relevant comparisons among ambulatory care facilities based on the information available.\textsuperscript{40}

\textit{Nursing Home Residents Can Rest…With Reduced Risk of Infection}

Legislative findings on the issue of pressure ulcers (bedsores) show this issue to be a significant public health concern.\textsuperscript{41} Bedsores may cause severe pain or lead to complications from infection. Since the elderly represent a majority of the residents in nursing homes, this puts them at heightened risk of acquiring pressure ulcers. New Jersey ranked fourth highest in the nation for percentage of nursing home patients with bedsores, according to a 2007 CMS survey.\textsuperscript{42}

As wide consensus demonstrates, using pressure redistribution mattresses is an effective way to treat and prevent pressure ulcers.\textsuperscript{43} Therefore, beginning on June 22, 2010, any time a nursing home replaces a resident’s mattress, it must be replaced with a pressure redistribution mattress.\textsuperscript{44} And by June 22, 2012, all nursing home residents’ mattresses must be replaced with pressure redistribution mattresses.\textsuperscript{45}

\textit{Why is the Medical Examiner Calling?}

In the event of the death of a resident, a long-term care facility must contact the resident’s next-of-kin as well as the county medical examiner.\textsuperscript{46} The facility must also provide the medical examiner with contact information for the decedent’s next-of-kin so the medical examiner can make every “practicable effort” to reach them\textsuperscript{47} to gather any potentially relevant information regarding the circumstances of the resident’s death, and to help determine if further investigation (e.g., autopsy) may be warranted.\textsuperscript{48}

\textit{Physical Well-Being}

\textit{Food-Conscious—With a Conscience}

A nursing home resident has a right to food and meals that meet “religious dietary requirements,” but the request must be made upon or prior to admission.\textsuperscript{49} Private-pay patients must agree to assume whatever additional costs may be incurred in providing special food requests.\textsuperscript{50} Medicaid residents also have the right to have their religious dietary requirements met: The facility must simply add the additional cost (if any) to its “Medicaid cost report for consideration under applicable reimbursement processes.”\textsuperscript{51}

\textit{Senior Transportation Funding Finds a Home}

This law increased funding for the Senior Citizen and Disabled Resident Transportation Assistance Program from 7.5 to 8.5 percent of deposited revenues in the Casino Revenue Fund.\textsuperscript{52} Also, the appropriations language governing funding for the program was finally given a ‘home’ in a codified section of the act, thus making it easier for lawmakers (and others) to locate.\textsuperscript{53}

\textit{Assisted-Living Facility Medicaid Disclosure: There May Not Be Room at the Inn}

Assisted-living facilities must provide any prospective private-pay resident (or the legal guardian, or anyone financially responsible for the resident) with an informational document explaining eligibility requirements to participate in a “federally approved 1915(c) Medicaid waiver program that provides assisted living services.”\textsuperscript{54} This document must be accompanied by a signed written statement from the assisted-living facility explaining,\textsuperscript{55} first, that the facility \textit{cannot guarantee} that a bed will be available for a Medicaid-eligible resident at the time he or she is determined to be Medicaid-eligible;\textsuperscript{56} and second, that the facility may transfer the Medicaid-eligible resident to a nursing home or other assisted-living center if no bed is available for a Medicaid-eligible resident at the time the resident becomes Medicaid-eligible.\textsuperscript{57}

However, if an assisted-living facility receives written notice from a private-pay resident that Medicaid eligibility is likely to occur within six months, the facility must inform the resident (in writing) of his or her position on any waiting list for a Medicaid-eligible bed (position as determined at the time the facility received notice from the resident).\textsuperscript{58}

\textit{Financial Concerns and End-of-Life Matters}

\textit{Consumer Protection}

\textit{Annuities and Seniors: Taming the Preatory Sales Pitch}

Broadly speaking, this body of legislation establishes specific standards and prohibitions governing how insurers, insurance producers and their agents or representatives may interact with senior citizen clients in connection with annu-
ieties products. In general, those involved in the sale of annuities must not use any professional designation, certification, or form of advertising that is untrue, deceptive, false, or in any way misleads consumers about special qualifications, credentials, education or specialization in the handling of retiree or senior citizen clients. However, titles and designations associated with an academic degree are permissible, provided the degree is from an accredited institution of higher education; and provided the title or designation is not misleading or used in a deceptive manner in connection with any aspect of the annuity sales process.

Professional job titles or designations indicating seniority or specialization may be used by representatives whose employer company is licensed or registered with a state or federal regulatory agency that oversees financial services institutions and investment companies. But again, the title must not be misleading, untrue, or used in a false or deceptive manner in connection with any aspect of an annuity sale.

A section of this law provides for the exclusion of several types of annuities from disclosure requirements, including a funeral insurance policy. But this same section provides for the creation and distribution of a buyer’s guide containing a description of different types of annuities, their standard features, consumer information about the sale and negotiation of annuities, and notice of a minimum 10-day cancellation period for purchasers of annuities. The buyer’s guide is available on the Department of Banking and Insurance website, and a copy is also to be provided to the buyer by the seller of the annuity. In addition, the person selling the annuity must provide the buyer with a disclosure statement, separate and apart from the annuity itself, which plainly states and delineates key information about the transaction. These consumer documents, both the buyer’s guide and the annuity contract disclosure, must be delivered to the applicant buyer within five days of receipt of the application.

Standards for establishing the suitability of an annuity product for a client require the seller have reasonable grounds to support the belief the negotiation or sale of an annuity is appropriate for that client. The seller must make reasonable efforts to obtain and record facts disclosed by the consumer regarding: financial circumstances; tax status; insurance products; investment objectives; and any other information relevant to determining the suitability of an annuity product for a particular consumer. The record should also contain a consumer acknowledgment that the seller provided contact information for the Department of Banking and Insurance’s consumer assistance services, and that the consumer understands the department has regulatory authority over the entire annuity sales transaction, including suitability for that consumer.

Another protection in this act is the 10-day cancellation period after the purchase of an annuity, with the exception of those annuities subject to exclusion by Section 5 of the act. An annuitant has 10 days after the date of receipt of the annuity to cancel it. Upon the surrender of an annuity accompanied by a written request for cancellation, the insurer shall promptly refund any of the annuity’s account value plus contract fees or other charges.

Punishing Producers Who Don’t Come Clean

Another legislative enactment with derivative consumer protection benefits is a self-reporting requirement for licensed insurance producers. If an insurance producer is formally disciplined by the Financial Industry Regulatory Authority (FINRA) or similar non-governmental regulatory organization that oversees industry conduct, it must be reported to the commissioner of banking and insurance within 30 days. Failure to report disciplinary action taken by a regulatory authority may result in civil penalties and/or suspension, revocation, or refusal to renew or issue a license.

Protection Against Impostor Professionals

Under prior law, the occupational and professional licensing boards and commissions that regulate Title 45 professions were unable to adequately investigate or punish violations of unauthorized practice of these professions. In the interest of public safety, health and welfare, this law expands and enhances the investigative and enforcement powers of these boards and commissions.

When a violation is believed to have occurred, either the director of the Division of Consumer Affairs or the boards and committees within the Division of Consumer Affairs may initiate an investigation. A violation occurs when someone engages in the unauthorized practice of a regulated profession; or, when an individual who is not licensed or registered to practice a regulated profession represents the contrary to the public in any manner. After notice and a hearing, if the violator is found to have engaged in the previously alleged misconduct, an immediate cease and desist order will be issued. A fine will also be assessed—up to $10,000 for a first-time offense, and up to $20,000 for any subsequent offenses.

Consumers may search for licensed professionals through the following link for the Division of Consumer Affairs: www.state.nj.us/cgi-bin/consumeraffairs/search/searchentry.pl. Information on the complaint process may be found at: http://www.nj.gov/lps/ca/comp.htm; and complaint forms for professional and occupational licensing boards are available at: www.nj.gov/lps/ca-comlink.htm.
Asset and Funds Protection
Property Taxes Frozen—For Now or Until the 2010/11 Budget is Approved

The homestead property tax reimbursement is available to the disabled and those 65 years of age or older who meet the income and residency requirements. Under this program, property taxes are frozen at the “base year rate” if the applicant was eligible prior to Dec. 31, 1997; in such case, 1997 then serves as the base year. For anyone who attained eligible-claimant status after 1997, the tax year—the calendar year income was received and property taxes were assessed and levied—is used as the measure.

Language was added to the law to provide guidelines for those who move from a homestead where original eligibility had been established. Income requirements for 2007, 2008, and 2009 were also added, as well as guiding language regarding income adjustment for tax years 2001 to 2006. Additional relevant and current information is provided at: http://www.state.nj.us/treasury/taxation/propfrez.shtml.

Long-term Care Partnership Asset Disregard

Under this recent amendment to the law governing Medicaid recovery from the estates of qualified recipients, a new exception has been added. Medicaid shall not seek recovery from the estate of a deceased recipient if the recipient has been granted asset protection under the terms of long-term care partnership insurance according to the provisions of the “federal ‘Deficit Reduction Act of 2005,’ Pub. L. 109-171.” The asset amount protected is up to the amount disregarded at the time Medicaid eligibility was determined.

Pre-need Funeral Arrangements? Forget Funding with a Reverse Mortgage

There are two changes to the law regarding funeral insurance policies or pre-need funeral arrangements. One change requires that individuals who work on behalf of fraternal benefit societies to solicit or procure funeral insurance policies must be properly licensed as insurance producers (this category is no longer exempt from licensure). The other change prohibits pre-need funeral arrangements or pre-paid funeral agreements from being funded or financed through reverse mortgages. This change was promulgated by concerns about consumer lending practices.

Assisted-living Facilities Give Back

Residents of assisted-living facilities who provide at least 30-days’ notice of their intent to leave the facility may be entitled to a refund of their security deposit. If the security deposit was paid as a condition of admission to the facility, was a one-time payment, and was separate and apart from rent or other monthly charges, then the refund is required. The refund shall include any interest earned on the security deposit, and the facility may not deduct more than one percent per annum for the servicing of any account related to the handling of the security deposit.

Mutual Trust and Assurance...Over Cemetery Insurance

Funds furnished on a pre-need basis to cemeteries, funeral directors, undertakers, or any other entities that provide funeral- or burial-related goods or services, are to be treated as “trust funds” under the care of the recipient. These funds must be deposited into a special account with a federally insured bank or savings and loan, or if requested by the person supplying the funds, a type of trust account. No financial institution, however, shall be responsible for the misuse or misappropriation of moneys by any of the persons to whom the moneys were paid. But, in the unlikely event of professional misconduct, one could always refer to the above section on consumer protections for information relating to the complaint process for licensed professionals.

Conclusion

This survey of recently enacted legislation highlights some important benefits and protections New Jersey laws currently confer upon the state’s older residents. Some of these laws are more meaningful than others, and some will have a greater impact than others. But all of them, in some measure, should benefit senior residents and older clients in New Jersey.

Endnotes

1. N.J.S.A. 52:17B-194.4 et seq. (West, through Westlaw 2010).
5. N.J.S.A. 52:17B-194.6 (West, through Westlaw 2010).
8. Id.
9. Id.
10. Id.
14. Id.
15. Id.
18. N.J.S.A. 24:6I-2 (West, through
Westlaw 2010).


20. Id.

21. Id.


24. Id.


26. Id.

27. Id.

28. Id.


30. Id.

31. Id.


33. N.J.S.A. 26:2H-5.1c (West, through Westlaw 2010).

34. Id.

35. N.J.S.A. 26:2H-5.1d (West, through Westlaw 2010).

36. N.J.S.A. 26:2H-5.1e (West, through Westlaw 2010).

37. Id.

38. Id.

39. Id.

40. Id.

41. N.J.S.A. 26:2H-12.54 (West, through Westlaw 2010).

42. Id.

43. Id.

44. N.J.S.A. 26:2H-12.55 (West, through Westlaw 2010).

45. Id.

46. N.J.S.A. 52:17B-88a (West, through Westlaw 2010).

47. Id.

48. Id.


50. Id.

51. Id.


53. Id.


55. Id.

56. Id.

57. Id.

58. Id.


61. Id.

62. Id.

63. Id.


65. Id.

66. Id.

67. Id.

68. Id.


70. Id.

71. Id.


73. Id.

74. Id.


76. Id.

77. Id.


79. Id.


81. Id.

82. Id.

83. N.J.S.A. 54:4-8.67 (West, through Westlaw 2010).

84. Id.

85. Id.

86. N.J.S.A. 54:4-8.67 (West, through Westlaw 2010); see also 2009 N.J. Sess. Law Serv. Ch.129 (West, through Westlaw 2010).

87. Id.

88. N.J.S.A. 30:4D-7.2a (West, through Westlaw 2010).

89. Id.

90. Id.

91. N.J.S.A. 17:44B-32 (West, through Westlaw 2010); see also 2009 N.J. Sess. Law Serv. Ch.218 (West, through Westlaw 2010).

92. N.J.S.A. 45:7-90 (West, through Westlaw 2010); see also 2009 N.J. Sess. Law Serv. Ch.218 (West, through Westlaw 2010).

93. Id.


95. Id.

96. Id.


98. Id.

99. Id.

Marilyn Askin phased out her elder law practice in 2000 to become president of AARP-NJ, and is currently the organization’s chief legislative advocate. In 1985, she founded what is now the Elder & Disability Law Section of the New Jersey State Bar Association and received the section’s first annual Lifetime Achievement Award, named in her honor. She has taught elder law and social welfare legislation at Rutgers Law School, Newark, for the past 26 years. Jennifer Judd left the corporate business world to enter Rutgers Law School, Newark, where she is a second-year evening student, interested in pursuing a legal career in public interest law.
The 2004 National Football League draft was fast approaching, and the last-place San Diego Chargers held the first pick overall. Their expected pick, University of Mississippi quarterback Eli Manning, was no stranger to the inner workings of the NFL because his father, New Orleans Saints quarterback Archie Manning, and his older brother, Indianapolis Colts quarterback Peyton Manning, had preceded him to stardom.

Eli told the Chargers that he would not sign if the team selected him, and he intimated that he would instead re-enter the 2005 draft, expecting selection by another team. Sitting out the 2004-2005 season would mean losing a year’s multimillion dollar income in his athletic prime, but media reports indicated that the young quarterback also believed he could get a more favorable long-term contract from a team in a major media market.

The Chargers did pick Eli first. To avoid a stalemate that would leave them with nothing to show for the first round, however, they immediately traded him to the New York Giants. The rest, as they say, is history. Just ask any Giants fan about the team’s 17–14 upset victory over the New England Patriots in Super Bowl XLII in 2008.

How did future Super Bowl Most Valuable Player Eli Manning reach his high-stakes decision to spurn the Chargers and threaten spending a season on the sidelines?

“Eli did what I have always suggested in making big deci-
sions,” said his father. “I’m a legal pad guy. He took out a legal pad, drew a line down the middle, and put the pluses on one side and the minuses on the other side. It wasn’t even close, so he went with it.”

The Discipline of Writing

This sort of written decision making also aids presidents, legislators, judges, lawyers, business people, and others who recognize that the discipline of committing arguments to paper can focus thinking more clearly than more contemplation or oral discussion can. As author John Updike put it, writing “educates the writer as it goes along.” Indeed, said California Chief Justice Roger J. Traynor, writing is “thinking at its hardest.” “The act of writing,” concluded U.S. Circuit Judge Frank M. Coffin, “tells what was wrong with the act of thinking.”

At least three recent presidents—Richard Nixon, Jimmy Carter and George H.W. Bush—were also legal pad guys who methodically penned longhand lists of pros and cons to marshal their thoughts as they wrestled with major policy decisions. Other leaders reliant on such lists when mulling over vexing personal and professional decisions include Secretary of State Hillary Rodman Clinton; Secretary of Agriculture Tom Vilsack; Senator Blanche Lambert Lincoln; and former Senators Lloyd Bentsen, Sam Nunn, Lincoln Chafee and Paul Simon; former Treasury Secretary Robert Rubin; former Congress member and Sept. 11 commission vice-chair Lee Hamilton; former governors Michael Dukakas and Pete Wilson; and World Bank President Robert Zoellick. Even naturalist Charles Darwin made extensive notes listing the pros and cons of getting married before he proposed to his future wife.

Judges offer a solid rationale for written decision making. “All of us have had seemingly brilliant ideas that turned out to be much less so when we attempted to put them to paper,” said U.S. Circuit Judge Wade H. McCree Jr. “Every conscientious judge has struggled, and finally changed his mind, when confronted with the ‘opinion that won’t write.’”

Choosing the Format

Rather than listing pros and cons in two columns to express tentative decisions that won’t write, the decision maker might pen long passages, or even an informal essay. Handwritten diagrams or flow charts might also help. Felt need and personal preference determine the format because the point-counterpoint is normally for the writer’s eyes only, unless the writer shares the document with a small circle of advisors or other colleagues.

Regardless of the chosen format, writing can influence not only lawyers’ own personal and professional decision making, but also the advice lawyers provide clients about how to reach decisions on matters within the scope of representation. Some individual and institutional clients adept at problem solving may already understand how committing thoughts to paper induces careful reflection, but other clients may not.

Written decision making should come naturally to lawyers because it remains fundamental to the American judicial system, and thus to the way law schools teach students to ‘think like lawyers.’ In bench trials or actions tried to an advisory jury, Rule 52(a) of the Federal Rules of Civil Procedure requires the court to “find the facts specifically and state its conclusions of law separately.” The Supreme Court has recognized that “laymen, like judges, will give more careful consideration to the problem if they are required to state not only the end result of their inquiry, but the process by which they reached it.”

In United States v. Forness in 1942, the Second Circuit gave perhaps the most thoughtful judicial explanation of the prime goal of Rule 52(a). The unanimous panel included Judge Charles E. Clark, the chief drafter of the Federal Rules of Civil Procedure and an acknowledged expert in their meaning and application. Writing for the panel, Judge Jerome Frank said: “[A]s every judge knows, to set down in precise words the facts as he finds them is the best way to avoid carelessness….Often a strong impression that, on the basis of the evidence, the facts are thus-and-so gives way when it comes to expressing their impression of paper.” Judges hold no monopoly on this knowledge.

Appellate Decision Making

The appellate court’s full opinion or abbreviated writing shows litigants that the court considered their arguments, facilitates further review on remand or by a higher court, and defines the decision’s meaning as precedent. But the written word’s capacity to sharpen the decision makers’ internal thought processes looms large, as it did in the district court. “The process of writing,” said Justice Ruth Bader Ginsburg, is “a testing venture.”

Chief Justice Charles Evans Hughes found “no better precaution against judicial mistakes than setting out accurately and adequately the material facts as well as the points to be decided.”

Rule 52(a)

The trial court’s written findings and conclusions focus appellate review, permit application or preclusion doctrines, and inspire confidence in the trial court’s decision making. But the federal courts of appeals have also recognized a “far more important purpose” of Rule 52(a), “that of evoking care on the part of the trial judge in ascertaining the facts.” The Supreme Court has recognized that “laymen, like judges, will give more careful consideration to the problem if they are required to state not only the end result of their inquiry, but the process by which they reached it.”

In United States v. Forness in 1942, the Second Circuit gave perhaps the most thoughtful judicial explanation of the prime goal of Rule 52(a). The unanimous panel included Judge Charles E. Clark, the chief drafter of the Federal Rules of Civil Procedure and an acknowledged expert in their meaning and application. Writing for the panel, Judge Jerome Frank said: “[A]s every judge knows, to set down in precise words the facts as he finds them is the best way to avoid carelessness….Often a strong impression that, on the basis of the evidence, the facts are thus-and-so gives way when it comes to expressing their impression of paper.”

Judges hold no monopoly on this knowledge.
“Reasoning that seemed sound ‘in the head,’” U.S. Circuit Judge Richard A. Posner explained decades later, “may seem half-baked when written down, especially since the written form of an argument encourages some degree of critical detachment in the writer.... Many writers have the experience of not knowing except in a general sense what they are going to write until they start writing.”

Conclusion: The Human Factor

In *Forness*, Judge Frank acknowledged that “fact-finding is a human undertaking” that “can, of course, never be perfect and infallible.” Writing can certainly sharpened thought in everyday decision making, but the outcome depends on prudent use of the writing and other extrinsic sources of information and reason. Listing pros and cons can orient the decision maker, but the list offers no compass pointing ineluctably to the right answer. When President Bush pondered a Supreme Court nomination in 1990, for example, he took a legal pad and carefully penned the pros and cons of naming U.S. Circuit Judge David H. Souter, whose tenure on the Court did not turn out the way the president had anticipated.17

Because so much professional and personal decision making involves emotion and other intangibles whose force written words alone cannot capture, the outcome does not necessarily depend on which side of the ledger—pro or con—holds the longer list. Indeed, when Darwin pondered whether to propose to his future wife, his list contained 13 cons and only nine pros, but he married her anyway.18

The human factor, sometimes called a gut feeling, may tilt the scale and ultimately carry the day. When Thomas P. Schneider’s term as U.S. attorney for the Eastern District of Wisconsin ended in 2001, for example, he weighed offers to join large influential law firms at handsome salaries, plus friends’ suggestions that he cap his 29-year career as a prosecutor by running for state attorney general. “As most lawyers would,” reported the *Milwaukee Journal Sentinel*, “Schneider grabbed a legal pad and divided the page into two columns: pro and con.”19 Then his wife stepped in. “This is not a legal brief,” she told him. “This is your life.”20

And the rest is history, as it was with Eli Manning. Schneider rejected politics and lucrative private law practice to become executive director of COA Youth and Family Centers, an agency dedicated to improving poor Milwaukee neighborhoods by enhancing opportunities for needy children and their families. “I’ve always loved working with kids,” he said. “What I really care about is how you make a positive difference in this world.”21

Endnotes

10. 125 F.2d 928 (2d Cir. 1942).
11. Id. at 942.
17. Anne Reilly Dowd, supra note 5, at 68.
20. Id.
21. Id.

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