

1993

Elder Law in the Nineties

Peter J. Strauss

Follow this and additional works at: https://digitalcommons.nyls.edu/fac_articles_chapters

 Part of the [Elder Law Commons](#), and the [Estates and Trusts Commons](#)

Recommended Citation

Strauss, Peter J., "Elder Law in the Nineties" (1993). *Articles & Chapters*. 1129.
https://digitalcommons.nyls.edu/fac_articles_chapters/1129

This Article is brought to you for free and open access by the Faculty Scholarship at DigitalCommons@NYLS. It has been accepted for inclusion in Articles & Chapters by an authorized administrator of DigitalCommons@NYLS.

ELDER LAW IN THE NINETIES

Peter J. Strauss

The need to reconsider estate planning, placing a greater emphasis on life planning, is the theme of Peter J. Strauss's essay. He provides an overview of the status of the elderly in the United States and reminds the reader that the legal profession has not yet adequately addressed the needs of this segment of the population. The life planning components are discussed and corporations are urged to attend to such employee planning needs so as to enhance productivity at work and to improve the quality of their employees' lives.

Estate planning is in a state of evolution. Historically, new tax and substantive legislation and court decisions have been the natural selection stimulants. But forces of another kind have emerged: forces such as the growth of the older population, increase in health costs, competition for limited government dollars, and the failure of the existing social framework to deal adequately with these problems. It is these forces that have brought about this evolution and created the need to reconsider estate planning. What is needed is a greater emphasis on life planning, and not only by the elder law attorney servicing individual clients. Corporations, whose profits are reduced by employees' lessened productivity when they are called on to manage affairs for elderly family members, also must realize that enhanced life planning for their employees can benefit their bottom line.

The Growth of the Older Population

Persons over the age of sixty-five constitute the largest growing segment of America's population. Older Americans constituted 4% of the total population in 1900. In 1990, they constituted close to 12.5% of the total population. This number, 31.2 million Americans, will increase to more than 39 million Americans over sixty-five by the year 2010, almost 14% of the nation's total population. By the year 2050, almost 25% of all Americans will be over the age of sixty-five—a startling 65 million. Perhaps even more significant is the dramatic increase in

Peter J. Strauss is a partner in the firm Epstein Becker & Green, New York. This article is an extended version of an article adapted with permission from Michael Gilfix and Peter Strauss, *New Age Estate Planning: The Emergence of Elder Law*, TR. & EST., Apr. 1988, at 14.

Americans over the age of eighty-five. Although only 1% of the population today, it will double to 2% of the population by the year 2000 and increase to more than 5% by the year 2050.

The Increase in Health Care Costs

The increase in America's health care expenditures for the elderly and disabled is as dramatic. In 1955, health care expenditures totaled approximately 4.5% of the gross national product. Currently, health care expenditures total at least 14% of the gross national product, estimated at \$925 billion for 1993. These expenditures have increased at a rate three times the general rate of inflation during the past five years. Although inflation in general has leveled to about 3% to 4% annually, health care inflation continues to rise at a rate approximately 10% to 11% annually.

As the aging population of America grows, and as the mortality tables are extended, the problems of morbidity have increased dramatically. Mortality is the measure of the quantity of life; morbidity is the measure of the quality of life. As mortality rates have decreased, morbidity rates have increased in almost direct proportion. Senior citizens need less acute care treatment (skilled medical intervention by physicians and other practitioners or a hospital or skilled nursing home) than persons of younger years, but require significantly greater custodial and long-term care. Although the elderly constitute approximately 12% of the total population, they require 34% of all health care expenditures, most of this for the costs of long-term and custodial care.

Competition for Limited Government Dollars

The problems of senior citizens in relation to health care needs are compounded by the extremely limited benefits available to pay for long-term health care expenses. The nation's basic health care system for the elderly is the Medicare program, adopted in 1965, with some supplementation by private health insurance, affordable by some but not all Americans. Few Americans understand that Medicare does not cover the cost of long-term or custodial care; it is designed to pay only for the expenses of acute and skilled care. Thus, while hospital expenses are covered and part of physicians' fees are covered, most nursing home care is not paid for by the Medicare program nor is most home health care.

President Lyndon B. Johnson's 1965 prophecy that citizens would be able to insure themselves against the economic ravages of illness in old age has not been fulfilled. Senior citizens actually spend more on personal health care today than prior to the enactment of Medicare. As the Senate Special Committee on Aging concluded, "Medicare . . . has not effectively reduced the burden of health care

costs for the elderly and their families."¹

Although some good long-term custodial care policies are being sold, many older Americans cannot obtain them because the elder citizen is too ill or cannot afford the policies. As a result, a significant portion of the major expenses incurred by senior citizens are not reimbursed by any aspect of the national health insurance system. The elderly, therefore, enter their later years with little protection from the consequences of aging and morbidity. In some areas of the country, home health care can cost as much as \$30,000 a year. Nursing home costs can run from \$30,000 to \$80,000 a year (and, in a few nursing homes in the largest cities, over \$100,000). Although the very wealthy can handle these enormous expenditures without significant threat to their economic viability, and although the poor have protection under the Medicaid program, the vast majority of the American middle-class, elderly population is an economically endangered species, faced with financial disaster in their later years.

Although legislation is introduced in Congress from time to time to partially cover the cost of long-term care, it is unlikely that meaningful steps will be taken in the foreseeable future to relieve the elderly of the economic burden. The cost to the American society today of nursing home care and home care is approximately \$80 billion. Faced with present budget deficits, there is little likelihood that Congress will assume that additional economic burden. The reality is that the national health care system, designed as a program to benefit the elderly, in fact discriminates against the elderly and leaves major problems that must be addressed by society.

The Failure of the Existing Social Framework

Other significant problems are created by the growth of the aging population and the decline in the health of many older Americans. The loss of ability to manage one's financial affairs in later life because of illness or incapacity also places the senior citizen at risk. Elder abuse, both physical and financial, frequently occurs. Assets are lost or wasted because of lack of attention and proper management.

Most people have come to rational terms with the inevitability of death. Not so with the prospect of becoming incapacitated or disabled, in particular a cognitive disability, which remains a societal taboo. The mentally ill person or the victim of Alzheimer's disease is treated differently from the heart attack patient or the cancer victim. The latter is given sympathy and treatment, costs are paid for by private insurance and Medicare; the former is too often ostracized and

1. STAFF OF SENATE SPECIAL COMM. ON AGING, 101ST CONG., 2D SESS., *AGING AMERICA—TRENDS AND PROJECTIONS* 128 (Comm. Print 1990).

denied the financial benefits of private insurance and Medicare. The institutional care bias of our systems further exacerbates this discrimination.

Too often individuals become incapacitated without having planned ahead for financial management. In such cases, court intervention becomes necessary. All states have statutory procedures to allow appointment of a surrogate decision maker.

The traditional method for determining a surrogate decision maker has been the incompetency proceeding, during which the court would review the medical evidence and, if satisfied that a person was unable to function, would declare such person an incompetent and appoint a guardian or committee (an individual or individuals) to act on behalf of the incompetent. This process is time-consuming and expensive, involving legal fees, medical testimony, and fees to court-appointed guardians ad litem. It also stigmatizes the incapacitated person with the designation of incompetent, a term which has acquired unfortunate social implications, and deprives the patient of many legal rights, including the right to make a will, vote, and enter into a contract.

Most states have enacted a new procedure, the conservatorship (known in some states as limited guardianship). Under this proceeding, when a person becomes unable to manage his or her affairs, a conservator for the person's property is appointed. This procedure is somewhat less expensive than the full incompetency proceeding, focuses more on practical management issues, and involves less abrogation of other legal rights. The conservatorship also can be established for a limited duration. However, like the older guardianship or committeehip, it can be a cumbersome device to use because the court has strict control and supervision of expenditures. There are significant costs and a great loss of flexibility. Nevertheless, conservatorship may be the most appropriate—and only—procedure to use in many cases.

Conservatorship and guardianship are drastic alternatives of last resort. They result in heavy, or even a total, loss of autonomy. Enormous hostility is created within the family if someone charges that a parent has become mentally incapacitated. Sometimes there are conflicting claims and several people want to serve as conservator or guardian. Sometimes no one wants the job. The investigation and hearing are time-consuming, expensive, and tend to occur at times of crisis, when every day counts.

The legal system and the legal profession have been slow to respond to these problems. Intervention by the legal system historically has been only responsive to existing problems and crises. The system has not designed itself to play a preventive role in avoiding many of the problems of aging and disability. Although the states are improving and modernizing their guardianship procedures, with rare exceptions the need for court supervision can be avoided if proper planning is done.

The legal profession, probably because lawyers are no different than other

people, inadvertently has furnished legal services to clients, particularly elderly clients, in a way that mirrors the societal prejudice against aging. Lawyers traditionally focus on planning for death, not for the problems of life. Attorneys do an outstanding job of classical estate planning. Drafting wills, advising on life insurance matters, minimizing estate taxes, counseling on retirement benefits are all common aspects of "estate planning." All of these issues, however, focus on distributing estates at death or maximizing the amount of the estate to be distributed, or deal with the financial aspects of the healthy retiree. Little attention is given to planning for the client who may become disabled. It is the rare lawyer who includes the possibility of disability or incapacity as a major consideration in estate planning or takes into account the possibility of emasculating the client's assets as a result of catastrophic health care costs or long-term care.

Although lawyers intervene after the fact of a client's incapacity by bringing guardianship or conservatorship proceedings, they do not give enough attention to preventive steps that can be taken to provide for managing a client's affairs in the event of incapacity or to preserving the estate from depletion as a result of high medical costs, thus benefiting the client and the client's family. Nor do they give adequate attention to an issue thought to be the preserve of the medical community: decisions about the use or nonuse of life-sustaining treatment. Only a handful of practitioners would offer their clients a living will form without substantive advice because the issue is so undeveloped. Not viewed as a legal issue per se, it has not been considered an integral part of an estate plan.

By failing to consider these issues, many individual needs are not addressed. This dilemma is compounded, or perhaps caused, by a concomitant ignorance of the aging process. Painfully typical is the use of the wastebasket term *senility*, which for years has been a catch-all reference to elders who exhibited any degree of memory or behavioral difficulties.

The Call to Arms

Elder law is the name given to the collection of legal services now provided to address these issues specifically. Although the elder law attorney frequently engages in crisis intervention for an individual or family that faces health care emergencies, the focus is on planning. The goal of the elder law attorney is to shift the estate planning emphasis from the financial issues surrounding death to the issues—perhaps more important—of life.

Individuals and families need to work with their professional advisers to design a "life plan" which will create systems for efficient management of financial affairs and health, and personal choice decision making in the event of serious illness or incapacity. And they need to think ahead about how they can pay for the costs of long-term care if that should become necessary without impoverishing themselves and their families.

Fortunately, the elder law attorney can offer simpler, less expensive, more dignified alternatives to guardianship and conservatorship proceedings: the durable power of attorney (DPA) and the living trust. While a person is still competent, he or she can create one or a combination of these management alternatives that will be in place if they are ever needed.

The DPA is one of the chief tools. Under a power of attorney, one person (the principal) designates another person ("agent" or attorney-in-fact) to make decisions and carry out financial tasks. A power of attorney is durable if it remains in effect after the principal becomes incapacitated; a traditional, nondurable power of attorney ends at that point. (Durability can be assured simply by stating in the creating document that the power survives incapacity.) A variant preserving autonomy is the springing power of attorney which does not become effective until the principal is incapacitated. (Of course, the document must include a workable definition of incapacity.)

A popular planning strategy is to combine the DPA with a living trust. The trust can contain the bulk of the principal's assets or, on the other hand, can be unfunded until incapacity occurs. The trustee or attorney-in-fact then transfers assets into the trust which is administered for the benefit of the now-incapacitated older person. The trust provides income; it can be drafted so that trust principal can be used as needed by the trust beneficiary or beneficiaries; and it also provides skilled management of assets whose owners are uninterested in, or incapable of, managing them.

The attorney-in-fact or trustee must be chosen carefully. They must be honest, with the older person's best interests at heart; they must be able to devote time and effort to managing the trust; they must be aware of investment trends and the practical needs of the older person. The trust instrument and DPA themselves must be drafted carefully, with attention to practical needs; state law; federal income, gift, and estate tax consequences; and impact on Medicaid in situations where that program may be necessary to provide for long-term care.

Another part of the life-planning process involves methods for health care decision making when an individual lacks capacity to give informed consent and make his or her own decisions. It is the unusual person who is not concerned about the use or nonuse of life sustaining medical procedures and technology if that person were to become terminally ill, comatose, or be in a persistent vegetative state. We all have a constitutional right to refuse unwanted treatment (this is not suicide or euthanasia), and we do not lose this right to decide and refuse when we become incompetent. The question is: How are such decisions to be made—and by whom—when the older or incapacitated person cannot make or express a decision?

Here again the answer is advance planning through the use of living wills and health care proxies. A living will is a written statement of an individual's wishes about the kind and extent of health care treatment which that person

wishes to have or forgo in the event such a situation occurs. It states the individual's general philosophy about these issues and can express ethical and religious values that help formulate the person's views. The health care proxy—in effect a medical power of attorney—appoints a family member or trusted friend to advocate and speak for the impaired person and ensure that that person's wishes and decisions are effectuated. The law in most states now clearly endorses one's right to do this kind of planning. The problem of how to make decisions for persons who fail to address this issue remains; only a few states permit "substituted judgment" for life and death health care issues.

Yet another important part of life planning is the issue of financing long-term care. As previously noted, Medicare and Medicaid supplemental insurance will not be the payment source for ongoing home health care or nursing home care. Middle-income persons must think about this issue if they are to avoid economic devastation in the event of an illness requiring long-term care. Until a long-range, permanent answer is found, the only solutions will continue to be obtaining long-term care insurance or tapping the Medicaid program—a program enacted in 1965 as a program for the poor, but which has become the funding source for long-term nursing home care for the middle class—as the payor of last resort.

Long-term care insurance products are becoming better. The policies are less restrictive, the benefits improved, and premiums show signs of stability and, in some cases, are coming down as the result of increasing competition and state regulation. The purchase of a long-term care insurance policy should be considered by everyone as part of the planning process; a good policy may be the key to avoidance of economic disaster. But for those whose financial situation or health status precludes obtaining insurance, Medicaid may be the only alternative to finance long-term care. Although the debate rages as to whether it is proper and ethical to use Medicaid to pay for the long-term care of a person who is not poor, Congress has acknowledged that Medicaid is the nation's current long-term care financing system by its inaction in creating other solutions and by liberalizing the eligibility rules through changes made in the 1988 Medicare Catastrophic Coverage Act legislation.

As a corollary to the life-planning issues, one of the deepest needs of most older people is for autonomy—the ability to make their own decisions, for as long as possible. If it is hard to communicate with a visually or hearing impaired or confused older person, the professional's temptation is to talk only to the child (What does your mother want? Does your father have safe deposit boxes?) and to take the child's word for what the parent wants. This is where the need for compassion and patience comes in!

An important goal of any elder care plan is to maintain the older person's dignity and autonomy as much as possible and to carry out the older person's wishes as much as possible. The professional's job is to advise the client of the

options. If, after getting appropriate advice, the client chooses an option that the professional thinks is less than perfect, the attorney must realize that people are allowed to make their own mistakes, whatever their age. Money isn't everything; saving taxes isn't everything; investment return isn't everything. The more expensive or less efficient plan may fit the client's values or family needs more closely.

Corporate Involvement

The elder law attorney providing services to individuals is not the only one who should be concerned with these life-planning issues. The problems created by lack of adequate planning attach not only to the individual but to society as a whole, with an especially adverse effect on the corporate world. Therefore, corporations should be as actively involved as the individual practitioner in life-planning services as a way to avoid these problems.

Although the problems of aging affect individuals in dramatic ways, the impact on the economy in general, and on American corporations in particular, may be even more serious. The cost to corporations to maintain employee and retiree health insurance is now a major issue nearing crisis proportions. Less well known or documented is the fact that corporations have found that a significant number of employees, both at the executive as well as the nonexecutive level, devote substantial job time to dealing with the problems of aging and disabled family members. This indirect cost is more serious than many corporations realize.

The results of a nationwide study sponsored by Fortune Magazine and John Hancock Financial Services published in 1989 reported that between 25% and 40% of employees in America have elder care responsibilities; 49% of corporate executives were personally responsible for an elderly person's care at the time of the survey or during the previous two years.² Four out of ten nonexecutive employees with elder care responsibilities reported that they had primary responsibility for the care of an elderly family member and that they devoted an average of thirteen hours per week to this task.³

The Fortune-John Hancock study showed that the predominant problems employees evidenced as a result of their elder care responsibilities were stress, unscheduled days off, lateness and early departures, above average use of the telephone, and absenteeism. The study found that corporate executives and employees alike agreed that employers should establish policies or programs that enable employees to deal with family issues impacting on work performance. Another important report published by *The Conference Board* in 1991 noted that what seems

2. Fortune Magazine-John Hancock Financial Services, *Corporate and Employee Response to Caring for the Elderly* 84 (Apr. 1989) (unpublished survey, on file with the author).

3. *Id.*

clear from national trends as well as research is that corporate recruitment and retention efforts can fall short as the result of family problems:

Productivity can suffer and absenteeism and tardiness can increase when employees experience conflicts between their work and family responsibilities. The family may bear the greatest brunt of the imbalance, but work attendance and performance is affected as well. . . . As with child care, elder care problems are largely the result of inadequacies in the social services available in the community. The complexity and duration of elder caregiving often increases stress levels, absenteeism, and quit rates beyond those caused by child care.⁴

Of course, as *The Conference Board* report states, women are more likely to be caregivers than men, assuming wider responsibilities, both physically and emotionally. For example, in a study at The Travelers Companies, women caregivers spent an average of 16 hours per week performing caregiving duties, whereas men reported only an average of 5.3 hours to these tasks.⁵

The need to address these issues from the corporate perspective is clear. It is in the economic interest of business to do so. As *The Conference Board* concluded, there is evidence suggesting that work-family programs can improve a company's bottom line. To what extent have U.S. corporations been following this advice?

To date it appears that, at least in the elder care context, the corporate response is limited. Programs that have been instituted are largely designed to provide information and referral services to employees. Although there are some flextime programs, greater use of personal days off and unpaid leaves, some health policies which cover older family members, and a few companies that have offered long-term care insurance (usually at employee expense), information and referral programs have thus far been the backbone of corporate elder care programming.

As important as these programs are, more activity is needed. Companies need to do more if they are to cope with the effect on the work force of an aging population that will double by the middle of the twenty-first century. As Professor Michael A. Creedon of the Center for the Study of Aging of the University of Bridgeport wrote in 1988:

Corporate America has tremendous creativity, and, perhaps, we need a further period of experimentation. Of course, it is not the role of the corporate sector to become a welfare system, but rather to provide a work force environment that maximizes the productivity of employees and their capacity to be equally productive at home with their families.⁶

More companies need to provide seminars and educational materials to employees; they need to begin to help employees, as well as executives, to understand that advance planning—life planning—for their aging parents and themselves is critical. The corporate response to elder care needs must begin to be

4. Dana E. Friedman, *Linking Work-Family Issues to the Bottom Line*, 962 THE CONF. BOARD 7, 30 (1991).

5. *Id.* at 31, 32.

6. Michael A. Creedon, *Issues for an Aging America: Elder Care*, 911 THE CONF. BOARD 2, 3 (1988).

proactive rather than just responsive to employee crisis. Corporate investment in advance planning for the growing employee elder care burden will reap profitability rewards in a short period of time.

And there needs to be careful study given to a range of new products and services beyond information and referral that will aid executives and employees alike in dealing with aging and incapacity issues. Better health insurance, long-term care insurance, insurance counseling and claim assistance, independent care management services, bookkeeping and bill paying services, financial planning, and legal advice are just a few of the products and services needed to maintain the independence of older and disabled persons. The effectiveness and financing of these products and services must be studied.

Elder law, which began as a specialty designed to serve individual clients, has taken a very different turn. The lessons learned from serving individuals are now being applied to the broader problems of the business community. The techniques and strategies developed to deal with mom's or dad's problems can be applied to the larger corporate employee base and, together with offering new services, may well be the answer to a corporate problem that may soon equal the cost of health care in its scope and cost.