

# AGING IN AMERICA

CURRENT END OF LIFE ISSUES  
PAYING FOR LONG TERM CARE

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# THE U.S. – MORE OLDER PERSONS and PERSONS WITH DISABILITIES

	2010	2020	2030	2050
Total Population (In Millions)	310	341	373	439
<b>OVER 65</b>				
Percent	13%	16%	19%	20%
Number	40	54.8	72	88.5
<b>OVER 85</b>				
Percent	1.8%	1.9%	2.0%	4.4%
Number	5.7	6.6	8.7	19



# DISABILITIES AFFECT ONE-FIFTH OF THE POPULATION

- 49 million – 1 in 5 have a disability
- 43% (21 million) are between 18 and 64 years of age
- 54% (27 million) are over 65 years of age
- 1 in 10 have severe disabilities
- 9 million persons have disabilities so severe they require personal assistance to perform the activities of daily living





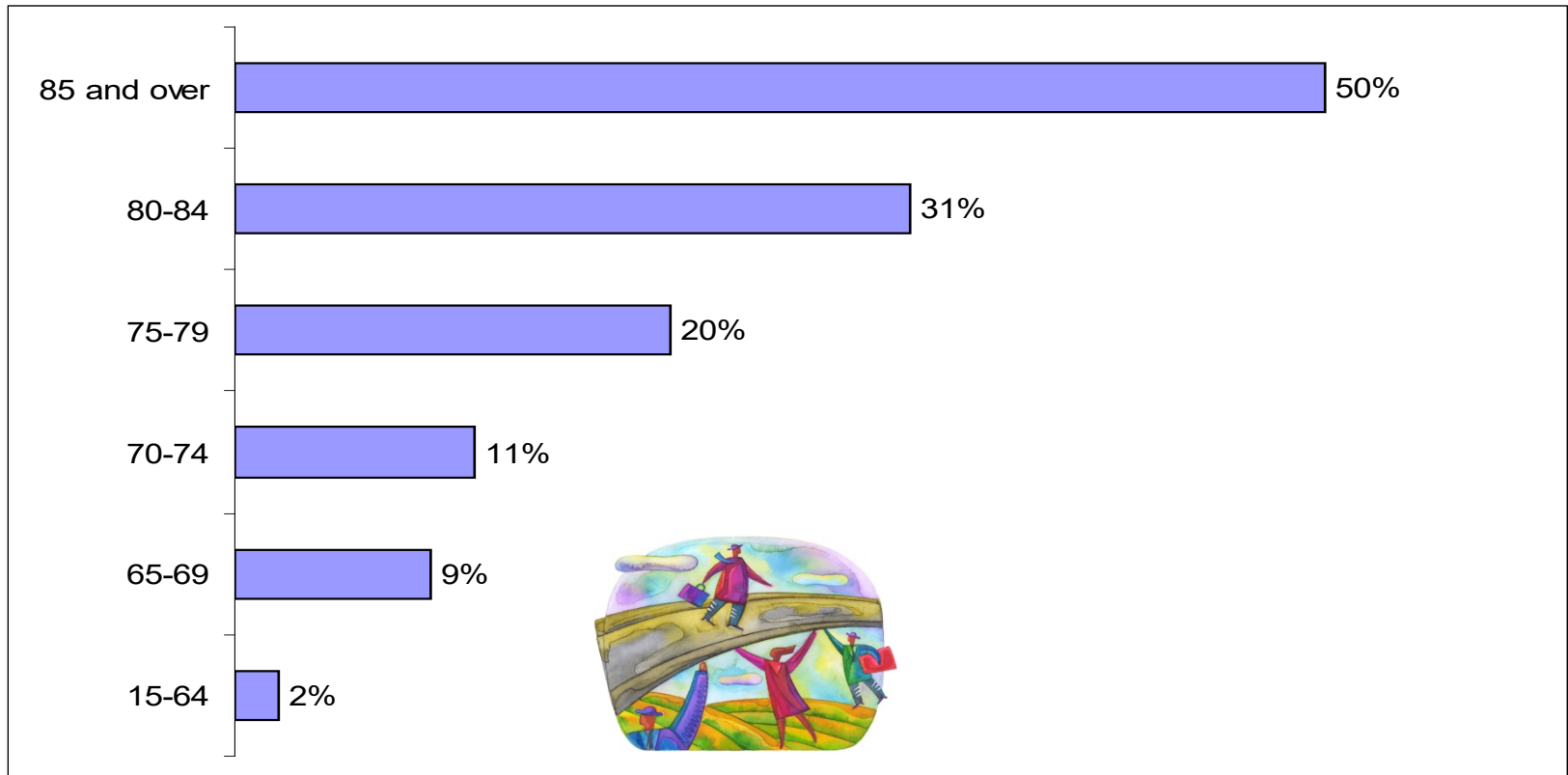
## GOOD NEWS, BAD NEWS



While this increase in life expectancy and the growth of our older population is positive, there is a negative side. 50% of persons over age 85 need significant assistance in daily functioning. Chronic disease such as arthritis, hearing impairment, hypertension, heart disease and stroke become more prevalent as persons age. The increasing prevalence of dementia among older Americans is a major factor; it is estimated that Alzheimer's disease is the cause of 70% of all dementia.



# THE NEED FOR HELP WITH EVERYDAY ACTIVITIES INCREASES WITH AGE



# THE FAILURE OF MEDICARE

MEDICARE is America's health care program for persons over 65 and for younger persons with disabilities who are not covered by an employer health insurance plan.

When Medicare was enacted in 1965, President Lyndon B. Johnson stated the following prediction of Medicare's benefits for the elderly:

"Every citizen will be able, in his productive years when he is earning, to insure himself against the ravages of illness in his old age. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years."



# PRESIDENT JOHNSON WAS WRONG!



Because Medicare only pays for acute care and skilled care, persons who suffer from long term, chronic illness do not have their needs met.

More physicians dropping out – no longer participating because of low re-imbusement rates.

The absence of long term care benefits for the incapacitated person and the caregiver is a leading cause of inappropriate institutional placement.

See *New York Times* Article published May 2, 2016, “South Dakota Wrongly Puts Thousands in Nursing Homes, Government Says.”

“When patients in South Dakota seek help for serious but manageable disabilities such as severe diabetes, blindness or mental illness, the answer is often the same: With few alternatives available, they end up in nursing homes or long-term care facilities, whether they need such care or not.”

# HEALTH CARE and SENIORS UNDER TRUMP



- Medicaid - Block Grants to States
- Medicaid – More “Waivers”
- Elimination of 3.8% investment income tax
- Reduced budgets for Area Agencies of Aging
- Medicaid – Closing state option to elect higher homestead exemption  
\$560,000 – to \$840,000  
(California, Connecticut, DC, Hawaii, Idaho, Maine, Massachusetts, NJ, NM, NY and Wisconsin)
- “Observation Status” Issue  
3 day hospital stay requirement – condition of rehab or home care benefits



# TAX REFORM and THE ELDERLY: KEY POINTS



It's not clear: some will benefit. Others, especially in high tax states like New York, will be adversely affected

- The *higher standard deduction* and *lower tax rates* will certainly benefit “the middle”
- The *additional standard deduction* in 2018 is beneficial

$\$12,000 + \$1,600 = \$13,600$  for single persons over 65

$\$24,000 + \$2,600 = \$26,600$  for married persons over 65

- Medical expense deduction was preserved *and* the threshold was reduced to 7.5% for 2018
- The right to make IRA transfers directly to charities was made permanent
- The reduction of the deduction for state and local taxes (SALT) to \$10,000 is obviously extremely harmful to seniors

# PLANNING AHEAD: TAKE CONTROL!

- Property Management
- Power of Attorney
- Trusts



# PLANNING AHEAD: TAKE CONTROL!

**THE FAILURE TO EXECUTE ADVANCE DIRECTIVES FOR *HEALTH CARE DECISION-MAKING AND PROPERTY MANAGEMENT* WILL RESULT IN LOSS OF INDIVIDUAL CONTROL AND AUTONOMY**

- Persons with little knowledge of a patient's wishes may become the decision maker
- A court appointed guardian may obtain the right to make end of life decisions
- The person who may be appointed guardian or be recognized as the "surrogate" may not be the person the incapacitated person would choose
- A partner in a non-traditional, loving relationship may have no authority to make health decisions
- These concerns apply for both health care decisions and financial affairs



## MAKING DECISIONS AT THE END OF LIFE

- The **doctrine of informed consent** was established by the case of *Schloendorff v. Society of New York Hospital*, 211 N.Y. 1 25 (1914) where Justice Benjamin Cardozo, then on the New York Court of appeals, wrote:
  - “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”



# “INFORMED CONSENT” INCLUDES THE RIGHT TO REFUSE TREATMENT

See *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261 (1990)

- “The common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment”
- “...the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be viewed from our prior decisions”
- This right exists even where the decision to decline treatment will result in death.



# Does the Right to Refuse Extend to Incapacitated Persons?

- In general, yes. *Matter of Quinlan*, 70 N.J. 10 (1976)
- Where a patient did not have advance directives and/or her or his wishes were not known most states have allowed a “surrogate” to make medical decisions, including end of life decisions, based on the theory of either **substituted judgment** or **best interests**
- Historically, New York applied a conservative approach to the right to refuse by requiring *clear and convincing evidence* of the patient’s wishes before life-sustaining treatment can be withheld or withdrawn. The clear and convincing evidence test can be met by oral testimony but the best evidence is a written document. *Matter of Westchester County Medical Center (O’Connor)*, supra; *Delia v., Westchester County Medical Center*, 120 A.D.2d 1 (1987)
- Where the clear and convincing evidence test is not met health care providers have been required to use all available medical treatment and procedures

# ADVANCE DIRECTIVES

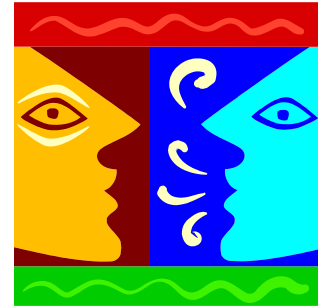
## The Health Care Proxy

- Allows a person to designate a surrogate - the health care agent - by executing a health care proxy.
- Sometimes called a “Durable Power of Attorney for Health Care”
- A competent adult may appoint a health care agent. (Note the use of the word “competency” rather than “capacity”
- Every adult is presumed competent “unless ...adjudged incompetent or otherwise adjudged not competent to appoint a health care agent....” (NY Public Health Law Section 2981).
- The health care agent’s authority to act begins when the attending physician determines that the patient lacks capacity to make health care decisions



# THE AGENT'S RIGHTS and RESPONSIBILITIES

The health care agent is required to make decisions based on the known wishes and values of the patient or if the patient's wishes are not known make "substituted judgment" or "best interests" decisions



The patient should:

- Provide clear guidelines with preferences regarding health care treatment.
- Discuss views and values with family and physician.

***Always appoint a successor agent***



# WHAT IS THE LEVEL OF CAPACITY REQUIRED TO EXECUTE A HEALTH CARE PROXY?

Determinations of capacity are a matter of state law. In New York, Public Health Law Section 2981 states:

“...every adult shall be presumed competent to appoint a health care agent unless such person has been adjudged incompetent....”

Do not assume a family member who has been diagnosed with dementia or who has had a stroke cannot sign a Health Care Proxy!

“The Health Care Proxy” by Peter J. Strauss,  
*Newsletter of the Alzheimer’s Association,*  
New York Chapter, April 2006



## ADVANCE DIRECTIVES - THE LIVING WILL

- A document which expresses a person's wishes about the type of care and treatment she or he would want or refuse
- Perhaps better called a "Health Care Declaration."
- The Health Care Declaration must be honored by the health care agent and health care providers, but compliance is spotty

## DRAFTING SUGGESTION

*“In the event I suffer from an injury, disease or illness which renders me unable to make health care decisions on my own behalf, which leaves me unable to communicate with others meaningfully, and from which there is no reasonable prospect of recovery to a cognitive and sentient life (even if my condition or illness is not deemed to be “terminal” and even if my death is not imminent), I direct that no medical treatments or procedures (except as provided in paragraph 4 below) be utilized in my care or, if begun, that they be discontinued”*

**Avoid using terms such as “terminal condition,” terminal illness,” “death is imminent” or “heroic measures.”**

Judicious application of the patient's instructions:

*"I emphasize that this directive to forego or discontinue treatment is to be applied when there is no reasonable prospect of recovery to a cognitive life where I can recognize and interact with my loved ones, but that I wish the medical treatments described above to be attempted if there is a reasonable possibility of such recovery in the opinion of my treating physicians. I understand that in such case, treatments may be instituted although later withdrawn if such recovery does not occur."*



# SHOULD YOU SIGN BOTH A HEALTH CARE PROXY and A LIVING WILL?

**Yes!**

- The Living Will is clear and convincing evidence of the patient's wishes.
- Guides the agent's decisions
- Helps the agent deal with guilt.
- If there is no Health Care Proxy or the agents have died the Living Will stands alone and the patient's wishes must be followed.



# ISSUE FOR THE 21ST CENTURY - CAN WE HAVE ALL THE TREATMENT WE WANT?

## **“MEDICAL FUTILITY”**

- While most of us, if asked, would state that we do not want all treatment available if there is no quality of life, others may seek all treatment available because of religious or ethical reasons or a belief that “the cure is around the corner.”
- Having shifted the focus of power to the patient and establishing the principle that the patient’s wishes are paramount (patient choice), does the patient also have the right to everything medicine and science can offer?
- Can a physician or hospital refuse to furnish treatment that is considered as “futile?” Is patient choice unlimited? The states differ.

## AID IN DYING

- The US Supreme Court ruled that the right to have a physician prescribe terminal medication is not protected by the 14<sup>th</sup> Amendment to the U.S. Constitution as a liberty interest/privacy right or under the equal protection clause. State “assisted suicide” laws were not held to be unconstitutional.
- *Washington v. Glucksberg*, 521 U.S. 702 (1997)
- *Vacco v. Quill*, 521 U.S. 793 (1997)
- The Montana Supreme Court held in *Baxter v. Montana*, 224 P.3d 1211 (2009) that it is not criminal for a physician to prescribe terminal medications under the Montana Constitution.

# MORRIS V. NEW MEXICO

*Trial Court Decision – January 2014*

“This Court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying. If decisions made in the shadow of one’s imminent death regarding how they and their loved ones will face that death are not fundamental and at the core of these constitutional guarantees, than [sic] what decisions are? ... The Court therefore declares that the liberty, safety and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right under our New Mexico Constitution.”

**New Mexico Supreme Court reversed on June 16, 2016 – no constitutional right to aid in dying.**



## CURRENT LAWSUIT

- Myers v. Schneiderman, New York County, N.Y. Supreme Court (New York's trial court), commenced in February 2015
  - Plaintiffs: 4 dying patients, 4 physicians, a nurse and End of Life Choices of New York
  - Dismissed by trial court in September, Appellate Division affirmed in May 2016.
  - **N.Y. Court of Appeals affirmed on September 7, 2017. The court adopted a broad position essentially following the 1997 US Supreme Court decisions in Washington v. Glucksberg and Vacco v. Quill, even though plaintiffs did not argue federal constitutional issues, only NY State constitution and common law issues. (Judge Jenny Rivera's concurring opinion is noteworthy)**

# AID IN DYING IS NOT SUICIDE

- “...The mental health community recognizes a clear difference between the act of “suicide” and the choice of a terminally ill patient to bring about a peaceful death.”
  - Kathryn L. Tucker, “Give me Liberty at My Death: Expanding End of Life Choices in Massachusetts”  
*New York Law School Law Review*, <http://nylslawreview.com/201314-volume-58-number-2/>
- “Assisted Suicide” is being replaced by the term “Medical Aid in Dying.”
- Advocates are moving the debate surrounding the medical aid in dying options from a legal issue to a professional practice standard discussion. See Tucker article, *supra*.

# STATES WHERE AID IN DYING IS LEGAL

## By Legislation

Oregon 1997  
Washington 2009  
Vermont 2015  
California 2016  
Colorado 2016  
D.C. 2016  
Hawaii 2018

## By Court Decision

Montana 2009

In Oregon since 1997 1,749 persons have obtained a prescription for life ending medication; 1,127 have taken the medication

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct>

Oregon Population in 2014: 3.8 million

## States Where Death With Dignity Legislation Was Considered in 2018 (21)

Alaska	Arizona	Connecticut	Delaware
Indiana	Kansas	Maine	Massachusetts
Michigan	Minnesota	Missouri	Nebraska
New Hampshire	New Jersey	New York	North Carolina
Ohio	Oklahoma	Pennsylvania	Rhode Island
Tennessee			

**SOURCE: Death With Dignity National Center**

See: <http://www.deathwithdignity.org/take-action>

## Voluntary Stopping Eating and Drinking (VSED)

“Exploring the Option of Voluntary Stopping Eating and Drinking within the context of a Suffering Patient’s Request for a Hastened Death,” Judith Schwarz, Ph.D., R.N., *Journal of Palliative Medicine*, Vol. 10, No. 6

## TERMINAL SEDATION

Patient is given high doses of a sedative which causes unconsciousness until death. Legal and accepted medical practice.

## RESOURCES

Several other end-of-life issues were discussed at a Symposium at New York Law School on November 16, 2012. The papers presented by the speakers can be found at

<http://www.nylslawreview.com/freedom-of-choice-at-the-end-of-life/>

# ELDER ABUSE

## Physical and Psychological Abuse

### Financial Abuse

- “The Met Life Study of Elder Financial Abuse: Comes of Occasion, Desperation, and Predation Against America’s Elders”
- <http://metlife.com/mmi/research/elder-financial-abuse.html>
- “Report of the New York State White Collar Crime Task Force,” July 2013
- 75% of financial abuse is attributable to family members
- Be careful with the gift rider/provision is a power of attorney!
  
- Eversafe – Elizabeth Loewy – 21 W. 46<sup>th</sup> Street, New York, NY 10036
  - Monitoring program for accounts of vulnerable persons

# MEDICARE

- **47 Million Americans are enrolled in Medicare**



- 39 million 65 and older
- 8 million non-elderly with a permanent disability or end stage renal disease

- **Part A – Hospital Coverage (2019)**



- Days 1 – 60 \$1,364 deductible, no co-insurance
- Days 61 – 90 \$341 per day co-insurance
- Days 91 – 150 \$682 per day co-insurance (lifetime reserve days)

- **Part B – Physician Services (2019)**



- \$183 deductible
- Higher premiums - \$134 (or higher depending on income)
- Skilled Nursing Home co-insurance (Days 21-100) \$170.50



# MEDICARE: LIMITED NURSING HOME and HOME CARE COVERAGE



Provided a beneficiary is admitted to a NURSING HOME within 30 days following a three day hospital stay, beneficiary is allowed a maximum of 100 days of skilled care.

- The first 20 days of skilled care are fully covered.
- Days 21 through 100 have a co-insurance payment of \$170.50 (2019) for skilled care.
- HOME CARE beneficiaries are entitled to by law to up to 35 hours a week for “part time and intermittent” skilled care but in reality get only a few hours a week.
- GOOD NEWS! Settlement in Jimmo v. Sibelius class action will result in increased benefits by eliminating the Medicare “Improvement Standard.”



- **BAD NEWS:** The “observation status” problem



# LONG TERM CARE INSURANCE

- Long-term care insurance for those who can afford it and for those who can meet medical underwriting criteria may offer a viable option for financing long-term home care and nursing home costs.
- Long-term care insurance may also be used as an integral part of an overall financial plan which can protect the assets of an impaired senior citizen by financing the costs of nursing home care during the Medicaid period of ineligibility after asset transfers either outright or in trust are made.
- If you have long-term care insurance you may not need to prematurely divest yourself of your assets and can keep your ownership of assets until it appears that institutionalization is necessary.

# THE PUBLIC-PRIVATE PARTNERSHIP

- New York has enacted a plan that allows you to keep your assets when you apply for Medicaid if you have a “partnership” long term care policy
- Your spouse’s assets are also protected
- Problems: No income protection for the recipient; Medicaid benefits only in New York
- Other states also have a “partnership” plan
- Asset protection only for amount of insurance

• See <http://nyspltc.org>

# USING YOUR LIFE INSURANCE TO PAY FOR LONG TERM CARE COSTS

- “LIVING BENEFITS” or ACCELERATED BENEFITS RIDERS
- “LIFE SETTLEMENTS” (“VIATICAL SETTLEMENTS”)

## LIVING BENEFITS RIDERS - ALSO KNOWN AS “ACCELERATED BENEFITS” RIDERS

- You may be able to draw down the face value of your life insurance policy on a discounted basis to pay for long term care.
- Many insurance companies provide riders allowing for withdrawal of the face value of a policy in the event you:
  - Are terminally ill
  - Need permanent institutionalization or
  - Need ongoing care at home

# LIFE SETTLEMENTS

## (Viatical Settlements )

- It may be possible for you to sell your life insurance policy to a private company which will buy the death benefit on a discounted basis
- The discount will depend on the life expectancy and health of the insured
- The funds you receive will not be counted as income if you take the benefits because you are a “qualified taxpayer” – meaning you are unable to perform at least 2 “activities of daily living”

# REVERSE MORTGAGES

- If you are over age 62 you may be able to borrow on the equity in your home without having to repay the loan until you sell your home or die.
- Interest accumulates.
- The older you are, the more you can borrow.
- Leading program is HUD's Home Equity Conversion Program ("HECM"). Loan can be obtained based on home values capped at \$675,000. The borrower can obtain a loan based on a percentage of the home's value (no more than \$675,000).
- Private bank "jumbo" reverse mortgages are presently not available.
- It had been possible to get a reverse mortgage on a *cooperative apartment* in New York for "jumbo" loans, but HUD does not yet permit this for HECM loans. The FHA recently advised that its policy will not be changed. See New York Times, August 28, 2014 "reverse mortgages co-ops unlikely"
- Recent FHA rules will limit the number of persons eligible for reverse mortgages and the amount of "up front" cash withdrawals.

## CONGREGATE CARE COMMUNITIES

- Certain congregate care facilities may provide long term health care benefits for residents at reasonable costs.



# MEDICAID - THE PAYOR OF LAST RESORT

- The Medical Assistance program, commonly known as “Medicaid,” was created in 1965 by the same legislation that created the Medicare program. Medicaid is a health insurance program for the poor, providing benefits to persons of limited financial means.
- To be eligible
  - You can own no more than \$15,450 of “countable” assets (In most states only \$2,000)
  - Be a resident
  - Be “medically needy”
- Certain property is exempt (not countable) in determining an individual's eligibility including
  - Your home – subject to new caps of the value of equity (up to \$840,000). However, the home remains exempt even if the value is greater so long as your spouse or a minor, blind or disabled child resides there
  - An automobile
  - Essential personal property
  - Funds in qualified deferred compensation plans if you are in payout status

# GIFTING ASSETS TO QUALIFY MEDICAID

- Since Medicaid is a “means tested” entitlement program, there will usually be a period of ineligibility (the “penalty period”) if the applicant “transfers” assets (i.e., give away without receiving something of equivalent value)
- **Transfer of Asset Rules Pre-February 8, 2006**
- Within 36 months of filing a Medicaid application (the “look-back period”)
- This penalty period started on the first day of the month after the transfer and is a number of months determined by dividing the total amount of the gifts by the average cost (at private pay rates) of a nursing home in the community in which the Medicaid applicant resides
- **Transfer of Asset Rules on or after February 8, 2006** (effective date of Deficit Reduction Act of 2005 – “DRA”)
- **60 month look-back period**

# BIOGRAPHY OF PETER J. STRAUSS

- Peter J. Strauss is Senior Partner in the law firm of Pierro, Connor & Strauss, LLC, with offices in Latham, New York and New York City. He was formerly of counsel in the Private Client Group at Drinker Biddle & Reath, LLP, and a partner at Epstein Becker & Green. He is also Distinguished Adjunct Professor of Law at the New York Law School, where he teaches Elder Law and is director of the Guardianship Clinic. He has practiced trusts and estate law since 1961 and has special expertise in the legal problems of aging and persons with disabilities, end of life decision-making and is a frequent lecturer on those issues. Mr. Strauss was elected as a Fellow of the American College of Trust and Estate Counsel (ACTEC) in 2013. He is a graduate from Bowdoin College and N.Y.U. School of Law.
- Mr. Strauss is a prolific author and has written articles for various publications including the *New York Law Journal*, *Bottom Line Personal*, *Trusts & Estates*, and *Strength for Caring* and has addressed many national professional and consumer organizations. He is co-author of "Aging and the Law" a treatise for professionals published by Commerce Clearing House, Inc. and a consumer book, "*The Complete Retirement Survival Guide: Everything You Need to Know To Safeguard Your Money, Your Health and Your Independence*," (Facts-on-File, Inc.) Professor Strauss is considered as one of the pioneers in the field of Elder Law, is a founding member (1988) and one of the four first lawyers to be elected as a Fellow of the National Academy of Elder Law Attorneys. He served as the original counsel to the National Association of Professional Care Managers (now Aging Life Care Association), is presently a member of the Board of Directors of Judges and Lawyers Breast Cancer Alert and End of Life Choices New York.

- Mr. Strauss has special interest in issues involving capacity for the execution of legal documents and the legal issues and rights of persons with respect to health care treatment and decisions at the end of life and is a member of the Board of Directors of End of Life Choices New York. He also handles guardianship matters and is known for his work concerning special needs trusts for persons with disabilities.
- Mr. Strauss has recently been awarded the New York State Bar Association Attorney Professionalism Award for 2019. Among other accolades are his designation for the years 2007 through 2016 as one of the New York Metropolitan area's "Super Lawyers" and "Best Lawyers" for 2007-2019. He was named the "Best Elder Law Attorney in New York" for 2012 by Best Lawyers. U.S. News & World Report has designated Mr. Strauss's former law firm, Epstein Becker & Green, as the best Elder Law firm in the United States in 2013.



# Thank You!

## QUESTIONS?

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