

# Real Property, Probate & Trust



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## Insurance for Condominium Developers

by Vincent B. DePillis, Real Property Law Group PLLC, Seattle

If you have a client who wants to build condominiums, the cost and availability of insurance are key factors in a decision on the feasibility of the project. This article is a primer on the difficulties and decisions your client may face. It is not intended to replace consultation with an insurance broker, but may help you get the lay of the land.

Most readers of this journal will be familiar with the problem. The Washington Condominium Act, Ch. 64.34 RCW (the "WCA") creates a strict warranty standard for condominiums (much stricter than the implied warranty of habitability which applies in this state to single family homes) and a right of action for breach of the standard, with statutory attorney's fees.

Under RCW 64.34.445, your client impliedly warrants in relevant part that the condominium is,

- (a) *Free from defective materials; and*
- (b) *Constructed in accordance with sound engineering and construction standards, and in a workmanlike manner in compliance with all laws then applicable to such improvements.*

Plaintiff contingency fee attorneys have used the WCA implied warranties to obtain millions of dollars in settlements from insurance companies, and as a result, unsurprisingly, liability insurance for condominium developers and builders has become astonishingly expensive and difficult to obtain.

As an introductory note, I should distinguish property insurance from liability insurance. Property insurance policies typically are not involved in construction defect cases, because

they do not cover the gradual deterioration of building components, unless there is an actual or imminent "collapse."

The Commercial General Liability ("CGL") Policy covers the insured (who could be the developer, but who could also be the contractor) for claims brought by others (e.g., a condominium association) for bodily injury or tangible property damage for which the insured becomes legally liable. CGL policy forms naturally contain dozens of limits, caveats and exclusions, but it has been helpful to me, in trying to understand these issues, to focus on four specific hurdles to coverage:

### First Hurdle: Is the Insured "Legally Liable"?

In the case of the developer (meaning the entity which actually sells the condominiums to the homeowners) there is no question about legal liability under the WCA implied warranties. But what about the contractor who actually did the work? If the contractor contracted with a developer, the contractor has no statutory, tort or contract duty to the condominium buyers. In these circumstances the key to coverage is the indemnity clause in the construction contract.

Here is how this works: the CGL policy usually excludes all damages that the contractor is obligated to pay as a result of "assumption of liability in a contract or agreement," unless the contract is an "insured contract." The definition of "insured contract" includes "that part of any other contract or agreement pertaining to your business ... under which you assume the tort liability of another party to pay for 'bodily injury' or 'property

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## Insurance for Condominium Developers

damage' to a third person or organization. Tort liability means a liability that would be imposed by law in the absence of any contract or agreement."

It seems to be the general understanding that indemnity clauses in the construction contracts are "insured contracts" for purposes of the CGL policies. It does not matter that the implied warranties under the WCA are not "tort liabilities" in common parlance, because they fit within the policy definition of a tort liability (fortunately for owners and contractors). Bear in mind that in the absence of an indemnity clause, the developer would have only a straight contract claim against the contractor, and the contractor's insurance would not be triggered.

**Practice Tip:** Because of the extremely litigious environment, some contractors will attempt to entirely vitiate the contract indemnity as it relates to homeowner lawsuits. This is counterproductive, because the contractor may still be liable for breach of contract, but in the absence of an indemnity, there is not coverage! It may seem counterintuitive to the contractor, but a broad indemnity clause may benefit both developer AND contractor.

### Second Hurdle: The "Your Work" Exclusion.

Standard CGL policies exclude damages arising out of "your work." At first blush, this would seem to make the policy almost totally useless to a typical contractor/developer, because the liabilities all arise out of the insured's work. The usual way around this is to confirm that you have "completed operations" coverage. With this coverage, damages arising out of the contractor's (or developer's) work are covered. The second way to get around the "your work" exclusion is the "subcontractor exception" to the "your work" exclusion. Under this exception, there is coverage for "your work" if the work is performed by a subcontractor. I understand, however, that this exception may not be available in all policy forms—especially if the completed operations coverage is not purchased.

**Practice Tip:** Make sure that you have a good subcontractor exception, and completed operations coverage.

### Third Hurdle: Is There Personal Injury or Property Damage?

The CGL policy is not triggered unless there is "tangible property damage" or "bodily injury." Unfortunately, the implied warranties under the WCA do NOT include damage as part of proof of breach. This creates an enormous gap between what can be insured, and the scope of the developer's liability. Examples of defects for which the insured is liable, but for which there is no coverage under a CGL policy, include esthetic issues, health and safety issues, and code issues which reduce the useful life of a building component, but which have not yet caused damage. There is no endorsement which can change this fact and close the gap in coverage. However, as a practical matter, if the insured can

show at least some damage, the insurance companies have been obligated to pay.

**Practice Tip:** There is not much that can be done in advance to deal with this hurdle. However, once the claim comes in, the issue of damage becomes a two-edged sword. From a practical point of view, the plaintiffs and the developer/contractor have an interest in phrasing the claims in such a way as to maximize the chances that the claim will be covered—*i.e.*, the insured is actually better off if the plaintiffs can show property damage. The insurer, on the other hand, may wish to defend in such a way as to maximize chances of denying ultimate liability under the policy. Clearly, the insurer's and the defendant's interests are not aligned in these circumstances. Many defendants hire, at their own expense, separate counsel to act as a watchdog over counsel appointed by the insurance companies, and to twist the insurer's arm at the settlement table.

### Fourth Hurdle: Did the Damage Occur in the Policy Period?

As explained in the article later in this issue by Larry Wagner ("*Practical Pointers: Insurance Terminology Creates Common Misconceptions of Policy Provisions*"), CGL policies may be "claims made" or "occurrence" policies. If a CGL policy is "occurrence" based, which is generally the preferable form, the damage must occur during the policy period in order to be covered. The insured must renew the policy every year. If the insured is dropped by the insurance company or cannot afford to renew or changes insurers, the policy does not, in theory, cover damage occurring after the policy period. Fortunately for Washington insureds (and unfortunately for Washington insurers), two Washington cases really hold the insurer's feet to the fire: Under *Gruol Construction Company v. Insurance Company of North America*, 11 Wn. App. 632 (1974), the court held that (1) dry rot was an "occurrence" within the meaning of the policy, even though it was an ongoing deterioration; and (2) that each of the three insurers was jointly and severally liable to the insured for the entire loss, even though only a portion of the loss occurred during each policy period. To make matters even better for the insureds (and disastrous for the insurers), the Washington State Supreme Court held in *American Nat'l Fire v. B&L Trucking*, 134 Wn.2d 413 (1998), that under the policy language there at issue, once the policy had been triggered (by damage), the insurer was liable for all damage thereafter occurring, regardless of whether it occurred during the time the policy was in effect.

Reading these cases, one begins to sympathize with the insurers, and to understand why they have raised premiums so high. Surely, insurers did not intend CGL policies as insurance against building defects. And yet courts have effectively allowed the policies to be used as such.

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## Insurance for Condominium Developers

**Practice Tip:** You may not be able to rely on case law interpretations of particular policy language if your policy differs. Buy completed operations coverage, from the outset, for at least 4 years, and preferably 6 years. To make sure that you will have insurance for the whole period of exposure, investigate a “Project Specific Policy,” meaning one which specifically insures the participants in a particular project, and where you pay the premium for the entire completed operations period up front. If you have purchased a policy for the project, the insurer can’t drop you midway through the period of exposure, or argue that the damage did not occur during the policy period.

### But This Costs Too Much! What Other Solutions Are There?

If you follow the practice tips outlined above, your client will receive a jaw dropping quote for liability coverage. Here is an example: for a 50 unit condo, you might receive a quote for \$2,000,000 in coverage for a premium of \$600,000, and a deductible of \$250,000. Defense costs may be inside the deductible, meaning in practice that your client will have to pay the entire defense cost, before getting a dime out of the insurer.

The client’s first reaction is to scream bloody murder and/or kill the project. After awhile, the client will suggest: (1) “Who needs insurance, I’m building this in a single asset entity anyway;” and (2) “I will be an additional insured on the Contractor’s policy in any case;” and (3) “I’ll put the \$600,000 into waterproofing the building—that’s better insurance!” If only it were so easy.

### The Pleasures and Perils of Doing Without Insurance.

There are a couple of arguments in favor of going without insurance. One argument is that the cost of CGL coverage (say, \$10,000 per unit) would be better spent on building quality—*i.e.*, that quality is ultimate defense. The second argument is that insurance attracts the suit—*i.e.*, that if there is no deep pocket, there will be no suit. It is hard to say how much weight to give these considerations. There are, however, several complications to going without insurance:

First, the client will have to pay for his or her own defense, unless he or she is willing to simply let the plaintiff enter a judgment against the development entity. Of course, if defense costs are inside the (sky-high) deductible, this becomes a moot point.

Simply letting a judgment be entered against the development entity is dangerous, because the plaintiff does have some ability to argue that the entity veil should be pierced. If the client simply allows a judgment to be entered, he or she will still have to defend the piercing claims, and the consequences of losing will be much greater.

Finally, it may not be possible for the client to go completely without coverage under the contractor registration laws (ch. 18.27 RCW). Under RCW 18.27.050 (as interpreted by WAC 296-200A-025), a “contractor” is required to obtain liability insurance. The amounts are *de minimis*, but, in many cases, the difficulty is that insurance is simply not available for residential construction at any price. Failure to obtain insurance exposes the “contractor” to fines and Consumer Protection Act liability. The traditional “builder,” who is building housing for sale and hiring different trades directly (without an intervening general contractor) is clearly required to be registered, while a “developer” of condominiums who hires a separate general contractor to do all the construction is exempt from registration under RCW 18.27.090(11). A word of caution, however: In conversations with Department of Licensing personnel on this issue, it has been represented to me that developers (who hire a single general contractor) are also required to be registered. No statutory or case law support was cited for this proposition, but caution is advisable whenever a bureaucrat’s reading of the law differs from your own.

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## ***Insurance for Condominium Developers***

### **But What About “Additional Insured” Status?**

In the usual course of events, the developer will be an “additional insured” on the contractor’s CGL policy. Developers may see this as a solution to the cost and difficulty of obtaining their own coverage. Unfortunately, this “solution,” if available at all, is neither free nor entirely satisfactory.

In the first place, if the project is a condominium, the contractor may not be able to obtain insurance—many contractor CGL policies now contain a “residential exclusion,” meaning that the contractor is not covered for residential work. If the contractor is actually able to obtain the insurance, the premium may be just as exorbitant as if the developer obtained it directly. And, inasmuch as a contractor charges the developer a prorated share of the contractor’s CGL premium cost, there may not be any cost savings.

Moreover, some contractors are not willing to name the developer as an additional insured unless the owner has its own liability insurance—because they do not want the entire risk to fall on their policy alone.

Finally, you should be aware that additional insured status is not as good as having your own insurance, for a variety of reasons, including:

- The contractor’s policy may not cover the developer for the developer’s sole acts—only for liabilities incurred as a result of the contractor’s acts.
- The contractor’s policy may not extend completed operations coverage to the additional insureds.
- The policy is not within the developer’s control. If the contractor goes out of business, changes insurers, etc., the developer’s additional insured status may lapse.
- The contractor’s limits for a particular period may be depleted by a loss on some other job.

### **Prospects for Change.**

As you can tell from this discussion, the news for your condominium developer clients is not good. Fundamentally, however, the reaction of the liability insurers to the avalanche of condominium lawsuits is entirely rational. Unless and until that avalanche begins to slow, or the insurers are able to revise their forms to exclude those risks, premiums will remain stratospheric.

In the long term, the solution may lie in creating a separate kind of insurance which is specifically designed to deal with construction defects. There are already examples of such policies (typically styled as “Home Warranties”) in the U.S. Unfortunately these warranties do not offer much coverage for the kind of code-compliance defects and water-ingress problems which drive our litigation crisis. In British Columbia, Britain, New Zealand, France, and other countries, there is a growing body of insurance practice targeted specifically on construction defects, which may offer an alternative path entirely.

If we were to remove construction defect coverage from the CGL coverage, and insure it separately under a construction defect policy, we would undoubtedly see a drop in the cost of liability coverage. But we might also see a more rational treatment of the construction defect issue in a separate policy form—detailed treatment of what is and is not covered, carefully defined limits and policy periods. Most importantly, we would probably see the development of an underwriting process focused specifically on building durability. Over time, it is possible that with careful definition of policy terms, and thoughtful underwriting, the cost of defect insurance would drop into a reasonable range. In the recent legislative session in Olympia, a bill was introduced which is a step in this direction (HB-5175); and, as of this writing, its prospects for passage seem favorable. There is, however, no guarantee that this approach will in fact work if adopted.

For the time being, there is not much you can do for your clients by way of obtaining adequate, affordable insurance coverage for condominium warranty claims, other than investigate the full extent of the bad news, and commiserate.

# Practical Pointers: Insurance Terminology Creates Common Misconceptions of Policy Provisions

by Larry V. Wagner, Vice President, Parker, Smith & Feek, Bellevue

In drafting the insurance provisions within leases, deeds of trust, and other documents, our objective is to correctly express the agreement of the parties on insurance-related matters and not to confuse or muddy the water as to what was meant. None of us wants to be guilty of committing a “Nova.” For those of you who don’t recall, Chevrolet came up with a model car and called it the Nova. When it went on sale in Central and South America, the car sold poorly, possibly because “No va” means “it doesn’t go” in Spanish.

Like Spanish, the insurance industry has its own unique terminology that, if not understood, can lead an attorney to inadvertently commit a “Nova.” A classic example of this is the use of the term “casualty.” Casualty often appears in a lease in the section requiring one or both of the landlord and tenant to maintain first party, direct physical damage property coverages. Certainly, if one uses a dictionary definition of casualty, the term refers to “a disastrous accident” or events with related meanings. However, in my industry, insurance is often referred to as “Property & Casualty” insurance. Property insurance is the first party direct physical damage coverage that is written on buildings, personal property, and other similar exposures—what one might normally think of as “casualty” insurance. “Casualty” insurance, on the other hand, refers to third-party legal liability coverage, commonly referred to as commercial general liability. Not a serious problem, but illustrative of the need to know what is intended and how to express it.

While both areas of insurance coverage, property and casualty, are fertile ground for terminology confusion and coverage misconceptions, this article will highlight some trouble areas that arise in creating documents with provisions for commercial general liability insurance.

## A. Commercial General Liability

### 1. “Occurrence” vs. “Claims Made” Policies

General liability insurance comes in two types: an “occurrence” form or a “claims made” form. Because an occurrence form policy will cover incidents that occur during the policy term regardless of when a claim is asserted and a claims-made form policy will cover only incidents as to which claims occur and are made during the policy term, an occurrence form will almost always be preferable and the best choice when drafting the insurance provisions for a lease or similar document.

### 2. Combined Single Limit

It is very common in today’s insurance world for general liability insurance to be written with what is called a “combined single limit.” That means that there is one limit per occurrence for all bodily injury and/or tangible property damage claims arising out of the incident. Years ago it was far more common to see split limits where there was one limit for each person, another for all

the people in the aggregate, and a third for property damage. In most instances, it is preferable to require a combined single limit in your documents.

### 3. Annual Aggregates

In addition to per-occurrence limits, commercial general liability policies contain annual aggregates with respect to limits. Because these aggregates can impact the available per-occurrence limit, it is prudent both to know what they are and to require that general aggregates apply on a per location basis. For contractors, aggregates should apply on a per project basis. (This general aggregate per-project or per-location has no bearing on the products/completed operations aggregate in the policy.)

### 4. Contractual Liability Coverage

Contractual coverages in the third-party legal liability section of insurance provisions warrant mention. Inevitably, these sections contain some phraseology that states that the party providing the insurance is obligated to have contractual liability covering all of the party’s indemnity obligations. Contractual liability coverage in a commercial general liability policy *does* apply to indemnities. However, indemnifications are usually broader than the grant of coverage given by the liability form. Therefore, you cannot buy contractual liability to insure *all* obligations under an indemnity provision in an agreement because the commercial general liability policy contains limitations and exclusions. This means that it is realistic to require the contractual liability be carried, but in most cases it is impractical to require the contractual liability be carried to specifically insure *all* obligations assumed under an indemnity. Examples of liabilities not covered would include intentional acts, pollution, sexual harassment, and non-owned aircraft.

### 5. Deductibles—Per Claim vs. Per Occurrence

Deductibles, whether the form of coverage being used is an occurrence form or a claims made form, can still apply on a per-claim basis as opposed to per-occurrence basis. If a deductible is written on a per-occurrence basis and a claim is made on a general liability policy, whether it be for bodily injury or tangible property damage, the deductible applies once, no matter how many claims arise out of the insured occurrence. Deductibles on a per-claim basis, on the other hand, apply to each and every claimant whether the policy involved is itself an occurrence or a claims-made policy. Therefore, for general liability coverage, deductible requirements should specify whether they are intended to be written on a per-occurrence or a per-claim basis.

### 6. General Liability Additional Insureds

In most cases, additional insured (AI) issues will pertain to liability insurance. Edition dates of forms (effecting AI status for

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products/completed operations) and primary-noncontributory are current hot topics. AI status for other than “ongoing operations” has, in the hard market, become a rarity. If available, it will often involve more premium. Noncontributory aspects are becoming less troublesome. It remains prudent to require that general liability additional insureds be on a primary-noncontributory basis. Loss payable forms are specific to first-party direct physical damage coverages; therefore, you would not require that someone be a loss payee on general liability coverages.

### **B. Failure to Procure Insurance**

In a lease, another provision that can lead to difficulties is the section dealing with a tenant’s failure to procure or maintain insurance. Most often, this section states that if the tenant fails to procure and maintain the required types or amounts of insurance then the landlord may purchase it for the tenant and require that the tenant reimburse the landlord for the cost. In some cases, this can create problems. If the landlord buys the tenant’s insurance, the landlord may in fact get the coverage written exactly as it was, only to find out after an incident that the coverage obtained by the landlord left some risk uninsured or that there is some other problem with coverage. The landlord could then find itself facing a claim from the tenant to the effect that once the landlord undertook to provide the tenant’s insurance, the tenant relied upon the landlord to procure adequate insurance. In such circumstances, a requirement intended to protect the landlord instead exposes the landlord to potential liability. It may therefore make more sense to write these sorts of provisions such that if the tenant does not procure or maintain the required insurance, the landlord may, but is not required to, procure any insurance it feels it needs to protect itself, with the tenant being responsible to reimburse the cost. The idea is to permit the landlord to protect *itself* if the tenant doesn’t, but not to have the landlord buy the tenant’s insurance for it.

### **C. Duration of Obligation**

The availability and cost of insurance products can affect insurance provisions. It is reasonable and prudent for the drafting attorney to keep in mind that the insurance market is a very cyclical industry. The availability of limits, the efficacy of the

terms and conditions of policies, and the cost of certain coverages can be widely available at high limits for a moderate cost one year and be cost prohibitive or unavailable the next. It may be appropriate to include provisions in documents that allow discussion and negotiation based on current insurance marketplace conditions. And remember that the insurance contract renews with a change in terms and conditions and available limits every 12 months.

As noted earlier, the topics in this article include only issues arising in commercial general liability insurance. Property insurance brings to the table its own set of issues, with such gems as the difference between earthquake and earth movement coverage, or the meaning of terms like “fire and extended coverage” or “all risk,” not to mention the question of what *is* an insurable value? Other kinds of insurance that are not even mentioned here—like boiler & machinery coverage, United States Longshore and Harborworkers Act insurance, liquor legal coverage, protection and indemnity (marine) insurance, and aircraft insurance—have unique issues as well. It is always prudent that the insurance brokers for the parties be involved in discussing the appropriate terminology and the implications of coverage decisions and of how the document is drafted.

*For additional information or clarification regarding these topics, please contact Larry Wagner at 425-709-3746 or [lvwagner@psfinc.com](mailto:lvwagner@psfinc.com).*

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# An Introduction to Long-term Care Insurance

by Claudia A. Gowan, LL.M, Editorial Board Member, Seattle,

with the assistance of Steven P. Hogg, CLU, ChFC, Manager, Financial Services, Edgren Hecker & Lemmon Insurance, Inc., Poulsbo

Today, estate-planning attorneys may be asked to review a long-term care insurance policy that has been offered for sale to or is already held by a client as part of the client's overall retirement and asset-protection plan. Long-term care insurance ordinarily provides benefits that cover some or all of the insured's long-term care expenses related to prolonged illness, disability or cognitive impairment; a few policies also provide a death benefit.

One of the most significant concerns that a client brings to any discussion of long-term care needs with his or her estate-planning attorney is how to pay for long-term care expenses in order to avoid serious depletion of retirement resources or the client's assets. Long-term care medical expenses are largely paid with private, personal resources. In addition, such expenses may be paid by long-term care insurance; they may be paid to a very limited extent by Medicare;<sup>1</sup> and, for those who qualify, some expenses may be paid by Medicaid. (For a discussion of this last topic, *see* the article by Jacob Menashe in this issue.)

Long-term care insurance policies are portable across state lines and, in some cases, across international boundaries. However, state laws and regulations governing the contracts vary. Where an individual is contemplating purchase of long-term care insurance and maintains homes in more than one state, the policy should be examined in light of the applicable law and regulations in each state from which the individual may wish to file a claim.

Ch. 48.84 RCW and ch. 284-54 WAC govern long-term care insurance policies issued in the State of Washington. RCW 48.84.020(1) defines long-term care insurance as:

any insurance policy or benefit contract primarily advertised, marketed, offered or designed to provide coverage or services for either institutional or community-based convalescent, custodial, chronic, or terminally ill care.

For purposes of this article, discussion will be limited to governing provisions of the Internal Revenue Code ("Code" or "I.R.C."), and state statutory and administrative code provisions.

## I. Two Broad Categories

Long-term care insurance policies may be either tax-qualified contracts under 26 U.S.C. § 7702B (1996), as amended, or nonqualified long-term care contracts.

Generally, premiums paid for tax-qualified policies are deductible within certain limitations, and benefits paid for services rendered under the terms of the contract are not treated as taxable income to the insured. Nonqualified contracts issued prior to January 1, 1997 that met state requirements for long-term care insurance contracts of the state in which the policy was situated and issued are treated as qualified long-term care insurance contracts for tax purposes.

Premiums paid for new (i.e., post-January 1, 1997) nonqualified policies may be deductible as a medical expense; however, the Code does not contain provisions that directly

regulate or authorize the deduction of premiums paid or the tax-free receipt of benefits under a nonqualified long-term care insurance contract. While the purchase of a nonqualified policy may be preferable in some circumstances, the taxpayer should be aware that the tax treatment of nonqualified contracts issued after January 1, 1997 is ill-defined.

## A. Tax-qualified Contracts

### 1. Requirements for Issuers and Failure to Comply

Requirements for issuers of qualified long-term care insurance contracts are found at I.R.C. § 4980C. Where an insurer fails to meet certain requirements of the model insurance act<sup>2</sup> or fails to disclose in the policy and the related outline of coverage that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Code, a tax of \$100 per insured will be imposed; the tax is assessed for each day the requirements are not met with respect to each policy contract. I.R.C. § 4980C(a), (b). The tax may be waived where the failure to comply is due to reasonable cause rather than willful neglect. I.R.C. § 4980C(b)(2). Tax-qualified policies must be delivered to the applicant within 30 days of the approval date. I.R.C. § 4980C(c)(2). If a claim under the policy is denied, the insurer must provide a written explanation of the denial and all information relating to the denial must be made available within 60 days of a written request from the policyholder. I.R.C. § 4980C(c)(3).

### 2. Policy Requirements

Under Section 7702B of the Code, a tax-qualified policy is any insurance contract which (a) limits the insurance protection to qualified long-term care services; (b) does not pay or reimburse expenses incurred for services reimbursable under Title XVIII of the Social Security Act (Medicare); (c) is guaranteed renewable; (d) does not provide cash surrender values or other payments that can serve as collateral for a loan or can be borrowed; (e) provides that refunds or premiums and all policyholder dividends are to be applied to reduce future premiums or increase future benefits; (f) meets required consumer protection provisions; and (g) includes a nonforfeiture provision.<sup>3</sup> I.R.C. § 7702B(b)(1)(A)-(F), (2)(C).

Refunds made at the death of the insured, or on complete surrender or cancellation of the insurance contract, may be an exception to the requirement described in clause (e) above. The refund may not exceed aggregate premiums paid. Any refund on complete surrender or cancellation will be includable in gross income to the extent that a deduction or exclusion from income was allowed. I.R.C. § 7702B(b)(2)(C).

The required nonforfeiture provision described in clause (g) above is met if the provision is properly captioned; if the issuer provides for a state-approved benefit in the event of a default in premium payment; and, if the contract provides for one or more of the following: a reduced paid-up insurance benefit, extended

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term insurance, shortened benefit period or similar offering. I.R.C. § 7702B(g)(4).

### **3. Tax Treatment**

Qualified long-term care insurance contracts are treated as accident and health insurance contracts. I.R.C. § 7702B(a). Amounts *received* (except dividends or premium refunds) are treated as amounts received for personal injuries and sickness and as reimbursement for expenses actually incurred for medical care defined under Section 213(d). *Id.* at (2). Amounts *paid* for a qualified long-term care insurance contract are treated as payments made for insurance for purposes of Section 213(d). *Id.* at (4). Generally, premiums paid for tax-qualified long-term care insurance contracts are deductible from taxable income in accordance with inflation adjusted age related limitations. Amounts reimbursed for qualified long-term care services are not includable in gross income; however, inflation-adjusted per-diem limitations may apply requiring the excess to be included in gross income—except where the insured is terminally ill. I.R.C. § 7702B(d). The per-diem limitation is equal to the excess of (a) the greater of (i) the per day limitation as adjusted for inflation annually and (ii) the costs incurred for qualified long-term care services provided to the insured over (b) the total payments received as reimbursement for qualified long-term care services for the insured. I.R.C. § 7702B(d)(2).

Insurers are required to report payment of long-term care benefits in accordance with Section 6050Q(a) of the Code. A written statement must be provided to the insured delineating the information reported. I.R.C. § 6050Q(b).

### **4. What Are Qualified Long-term Care Services?**

Qualified services are limited to necessary diagnostic, preventive, therapeutic or other medical or personal care services required by a chronically ill individual and provided pursuant to a plan of care prescribed by a licensed healthcare practitioner. I.R.C. § 7702B(c)(1). A “chronically ill individual” is either an individual certified by a licensed healthcare practitioner as unable to perform, without substantial assistance, at least two activities of daily living *for a period of at least 90 days* due to a loss of functional capacity or a person requiring substantial supervision to protect the individual from threats to personal health and safety as the result of severe cognitive impairment. I.R.C. § 7702B(c)(2)(A)(i)-(iii). “Activities of daily living” are enumerated in the Code: eating, toileting, transferring, bathing, dressing and continence. I.R.C. § 7702B(c)(2)(B)(i)-(vi). The Code specifies that a person shall not be considered chronically ill for purposes of Section 7702B unless the inability to perform two activities of daily living takes into account at least five of the preceding six activities of daily living. I.R.C. § 7702B(c)(2)(B). The terms “maintenance,” “personal care services” and “licensed health care practitioner” are also defined under Sections 7702B(c)(3) and (4).

### **B. Non-Tax-Qualified Long-Term Care Insurance Contracts**

One of the principle benefits of a nonqualified long-term care insurance policy is that benefits may be paid immediately upon eligibility under the policy terms. The requirement that an individual must be certified as a chronically ill individual having an illness or disability that will extend at least ninety days (*see* Part A(4) above) need not apply. Here, it is important to clarify that tax-qualified policies may provide benefits before 90 days elapse; however, the person receiving the benefits must be certified as having an illness that will continue at least 90 days. For nonqualified policies, this latter requirement is not applicable unless the policy terms have such a provision.

Under Washington law, benefits available through a tax-qualified policy may or may not be available for non-tax-qualified policies. For example, Washington requires that long-term care insurance contracts be guaranteed renewable but does not require that nonforfeiture provisions be offered. As noted above, the tax treatment of non-tax-qualified policies (*i.e.*, the deductibility of premiums and the taxability of benefits) is unclear.

## **II. Washington Law and Elements of Long-term Care Insurance Contracts**

### **A. Eligibility**

Like many other types of insurance, long-term care coverage is underwritten by issuers on the basis of medical considerations. Policies are available for persons between the ages of 18 and 84, and a few companies will underwrite policies through age 95. Insurance coverage may be limited or excluded for certain conditions; for example, by reason of alcohol or drug addiction, war-related illness or injuries, intentionally self-inflicted injuries or attempted suicide, and psychological or other nervous-system disorders or diseases. Some states require insurance companies to pay for Alzheimer’s or dementia diagnosed after issuance of the policy. Washington does not have a provision specifically relating to Alzheimer’s disease or dementia; however, an insurer is prohibited from limiting or excluding coverage by type of illness, accident, treatment or medical condition except for specific exclusions provided under WAC 284-54-050.<sup>4</sup> In addition, RCW 48.84.040 states that no policy or benefit contract may (a) limit or reduce coverage by use of riders, waivers or similar methods; (b) indemnify against losses from sickness on a basis that differs from accident losses; (c) be canceled, not renewed or segregated for re-rating purposes based solely on age, or physical or mental deterioration of the health, of the insured; (d) exclude or limit coverage for preexisting conditions for a period of more than one year prior to the effective date of the policy or more than six months after the effective date of the policy; (e) differentiate benefit amounts based on the type or level of nursing home care

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provided; or (f) contain provisions establishing new waiting periods where an existing policy is converted to a new form within the same company.

The state requires that long-term care policies are guaranteed renewable. WAC 284-54-030(7), -100. The requirement guarantees only the right to renew the policy, not the right to renew at the same premium. Insurers may decline renewal of coverage solely for nonpayment of premium. Premium rates may not be adjusted on an individual basis; premium rates may only increase for a class of policies. WAC 284-54-030(7).

Finally, insurers may not knowingly sell long-term care insurance to an individual who is receiving Medicaid; may not complete the medical history portion of an application to purchase the insurance, and may not use unfair or deceptive acts or practices in the marketing or sale of the insurance. RCW 48.84.060. Unfair or deceptive acts or practices are detailed at WAC 284-54-800.

### **B. Protections Against Lapse**

Under Washington law, every long-term care insurance contract must provide a minimum 31-day grace period following the due date for payment of premiums. WAC 284-54-250. Insureds are also protected from an unintentional lapse of the policy. The insured must be allowed to designate at least one additional person to receive notice of lapse or termination due to nonpayment of premium and any waiver of this right must be in writing. WAC 284-54-253(1). If the lapse of a policy is related to cognitive impairment or loss of functional capacity, the insurer must provide a limited right to reinstate coverage if the reinstatement is requested within five months after the policy lapsed or was terminated due to nonpayment of a premium. *Id.* at (2). Furthermore, in the event of cancellation or lapse, the nonforfeiture provision of a tax-qualified policy or a nonforfeiture provision selected by the insured as an optional benefit may provide for a refund of premium or entitle the insured to some benefits under the policy.

### **C. Types of Services**

Washington requires that long-term care contracts offered for sale in this state cover skilled, intermediate, and custodial or personal care services, irrespective of whether the benefits are for institutional or community based care. WAC 284-54-150(4). Ch 48.84 RCW applies to community-based care, institutional care, terminally ill care and adult day healthcare. WAC 284-54-020.

Community-based care includes, but is not limited to, home care, custodial or personal care, day care, home chore aid, nutritional services, respite care, adult day healthcare and similar services furnished in a setting that does not provide overnight care. *Id.* at (1).

Institutional care is that care provided in a hospital, skilled or intermediate-level nursing home or certified or licensed facility primarily offering diagnostic, preventive, therapeutic,

rehabilitative, maintenance or personal care services, including nursing services on a twenty-four hour basis. *Id.* at (5).

Terminally ill care is care for an illness or injury where recovery is no longer expected and the attending physician certifies that the patient is facing imminent death or has a life expectancy of six months or less. *Id.* at (9).

Adult day healthcare is a program of community-based social and health-related services outside of the individual's home. *Id.* at (10).

### **D. Benefit Triggers**

WAC 284-54-040 provides minimum standards under which benefits may be triggered. Every long-term care insurance contract issued on or after January 1, 1996 providing coverage to a Washington resident, with the exception of those policies issued under a group contract, must require certification by the attending physician of the insured that the services are appropriate due to illness or injury; or condition payment of benefits on the insured's ability to perform specific activities of daily living or the insured's cognitive impairment. WAC 284-54-040(1). Under the regulations, each contract must describe activities of daily living and cognitive impairment as the functional measurements of incapacity and the basis for eligibility. *Id.* at (2). The contract may include additional benefit triggers but must include the two described above.

Specific criteria under which an individual is eligible to receive benefits as the result of an inability to perform certain activities of daily living are provided by regulation. The benefit triggers are delineated in great detail and the regulation includes limitations on how restrictive a determination of deficiency that would prevent eligibility for benefits can be. WAC 284-54-040(3). The policy provisions regarding eligibility for payment of benefits may not require that an insured have a deficiency that renders the insured unable to perform more than three activities of daily living. *Id.* Activities of daily living must be defined in the policy and must include all of the following: bathing, continence, dressing, eating, toileting, transferring. *Id.* The definitions of activities of daily living encompass both the ability to perform the actual activity and the ability to conduct the movements necessary to effect the activity, for example, moving to and from the bath or managing a catheter or colostomy bag. Insurers may provide for additional activities of daily living, which may supplement those provided by regulation but may not be used in lieu of the above-required activities. *Id.* Determinations of deficiencies must not be more restrictive than requiring hands-on assistance in order to perform the activity of daily living. In the event of cognitive impairment, the deficiency must not be more restrictive than the need for supervision or verbal cueing by another in order to protect the insured or others. *Id.*

While all six of the activities of daily living on which an insurer may rely for federal tax-qualified long-term care insurance

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policy purposes are the same as the activities enumerated under WAC 284-54-040(3), the approach of the two codes differs slightly. The Internal Revenue Code requires that before an individual may be certified as chronically ill, the individual must be unable to perform at least two of the activities of daily living, I.R.C. §7702B(c)(2)(B)(i)-(vi), whereas the Washington Administrative Code prohibits requiring that eligibility for payment of benefits be contingent on a deficiency in more than three activities of daily living. WAC 284-54-040(3). For Washington state purposes, eligibility for policy benefits could be based on an inability to perform three or fewer activities of daily living. *Id.*

The opportunity to appeal denial of a claim or eligibility for benefits must be described under the contract and include a description of the appeal process and process for resolving benefit determinations. *Id.*

### **E. Policy Benefits**

Generally, long-term care benefits are paid using one of three methods: expense incurred, indemnity or disability. The expense-incurred method necessitates use of eligible services and a determination of the insured's eligibility for coverage. When those conditions are met, expenses are covered in accordance with the benefits that the insured purchased under the terms of the contract. Benefits may be paid to the insured or to the provider. The indemnity method is based on a predetermined dollar amount that the insured selected and purchased under the terms of the insurance contract; the method requires determination of the insured's eligibility for benefits and a determination of whether or not the services for which a claim has been made are covered under the policy. The benefit is paid to the insured. The disability method requires only that benefit eligibility is met; if the insured is eligible, benefits are paid even if the insured is not receiving long-term care services.

Benefits are typically provided for a defined period of time commencing with the first day that the insured begins to receive benefits under the policy, for example, two years, four years, or a lifetime. WAC 284-54-030(2). The benefit amount is determined by contract and is stated in terms of a daily benefit dollar amount. Typically the applicant may select from several options offered by the insurer. The benefit period ends when the insured has used the lifetime maximum benefits available under the policy terms. *Id.* In Washington, the benefit period must be stated in terms of days. *Id.*

Benefit periods may not be unreasonably limited and may not restrict coverage to a specified time period without regard to the actual amount of the benefits paid, for example, coverage for a particular condition may not be restricted to one year without regard to amounts paid or provided. WAC 284-54-150(1). The regulation also prohibits certain "gatekeeper" provisions or prerequisites to benefit payment; for example, no contract may restrict or deny benefits based on failure to meet Medicare

eligibility, no contract may require prior skilled or intermediate care as a condition of coverage, and no contract may require prior hospitalization as a condition of coverage. *Id.* at (5), (6), (7).

Benefits must be reasonable in relation to premiums charged; the regulations establish minimum loss ratio requirements. RCW 48.84.030(1), WAC 284-54-600, - 680.

### **F. Disclosure and Free Look Period**

Consumer disclosure is mandated in Washington. RCW 48.84.050(1). The required form of disclosure is outlined at WAC 284-54-350. The format of the contract is regulated under WAC 284-54-500. The insured has thirty days from delivery of a policy to return it unless the policy was solicited and sold by mail, in which case the insured has sixty days to return it. *Id.* at (2). Premiums paid must be refunded when a policy is returned; a ten percent penalty applies if the refund is not paid within thirty days. *Id.*

### **G. Optional Contract Provisions**

Washington requires that long-term care insurance offer optional inflation protection. WAC 284-54-270. The inflation protection features must be in one of three forms that are at least as favorable as the following: (a) annual increases in benefit levels with increases compounding at a minimum rate of five percent; or, (b) a guarantee that the insured individual may periodically increase benefits without evidence of insurability where the option had not been declined in the previous policy period; or (c) the insurance may cover a specified percentage of actual or reasonable charges without a maximum specified indemnity amount or limit. *Id.* The insurer may also offer additional inflation protection features as an option under the policy. *Id.* Consumers may also have the option of purchasing additional benefits, for example, a spousal discount entitling a husband and wife to a discount on the total premium amount where both purchase the insurance, a waiver of premium benefit relieving the insured of the obligation to pay premiums while the insured is receiving policy benefits, or a provision providing a refund of premiums paid minus benefits paid upon the death of the insured.<sup>5</sup>

## **III. Conclusion**

This article is not an exhaustive review of policy requirements or the many options relating to long-term care insurance that are made available by insurers. Evaluation of a long-term care policy necessitates review of your client's financial status, family medical history, the policy terms and the financial stability of the insurer. Even where the ability to deduct premiums paid for income tax purposes is not necessary, the tax-free receipt of benefits under a tax-qualified policy may be desirable. Finally, the length of benefit period and the amount of daily benefit should be considered in relation to prevailing costs in the area and potential non-covered expenses, for example, medication or equipment costs.

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# Recent Changes in Washington's Long-term Care Medicaid Program: More Restrictive Coverage/More Complex Rules

by Jacob H. Menashe, Isenhour Bleck, P.L.L.C., Seattle

## A. Introduction

After a good number of years with few changes to Washington's long-term care Medicaid program, last year saw several revisions that have, with one exception I'll detail below, made it more difficult to qualify for this government welfare program. These changes have also added layers of complexity to a program that already baffled many prospective applicants as well as, on some occasions, their attorneys.

In this article, I will provide a brief overview of our state's long-term care Medicaid program. Then I will go over, in more detail, the key changes that were made in 2003. Specifically, I will address: the new community spousal resource allowance; the new rules regarding trusts, including those that apply to spousal sole benefit trusts; the new gifting rules; and a new program that allows certain people to qualify for assisted living or adult family home coverage who would not have qualified under previous rules.

## B. An Overview of Washington's Long-term Care Medicaid Program

Medicaid is a state and federally funded medical assistance program for certain people, including the elderly and disabled, who have income and assets below specific limits. At the state level, the program is administered by the Medical Assistance Administration (MAA) of the Department of Social and Health Services (DSHS). While people can qualify for Medicaid in various ways—for instance, poor families with children who receive Temporary Assistance for Needy Families (TANF) also

receive Medicaid benefits—this article only addresses the rules that apply when someone requests long-term care coverage.

The state Medicaid program is authorized by RCW 74.09.500, *et seq.*, and the state regulations are found in the Washington Administrative Code (WAC), mostly at WAC 388-513 and 388-515. DSHS also has an internet manual. The old "Manual F" has been replaced by a new manual called "Eligibility A-Z." Its chapters on Adult Medical Programs and Long-Term Care have a significant amount of relevant material. MAA also maintains a federally required and approved "Medicaid State Plan" which describes what services and persons are covered, and the basic eligibility rules. The website where Eligibility A-Z can be found is: <http://www1.dshs.wa.gov/esa/eazmanual>.

Unlike Medicare, Medicaid will pay for custodial nursing home care and there is no limit on the number of days of coverage. More than half of the nursing home residents in the State of Washington have their care paid for by Medicaid.

In addition to providing nursing home coverage, Medicaid also covers assistance in the home or in an alternate care facility, such as an adult family home or assisted living facility, through a program called COPES, which stands for the Community Options Program Entry System. The financial eligibility rules for the COPES program, which our state administers under a "waiver" from the federal government, are very similar to those for the Medicaid nursing home program. (Please keep this concept of a "waiver" in mind, as a regulation I will cite below refers to "waivered" services or, in other words, COPES.) For purposes of this article, I will only be addressing a few of the differences between the general nursing home and COPES eligibility rules. There is one difference that will not be discussed below but that I always make sure my clients understand. Currently, it is very easy to use Medicaid benefits in a nursing home of choice. All but a few accept Medicaid (even considering they receive substantially less from Medicaid than they do from privately paying residents). However, it is much more difficult, especially in the Seattle area, to find an adult family home or assisted living facility that will accept COPES. This difficulty is especially pronounced when the care sought is for Alzheimer's or dementia.

Medicaid has strict resource rules that apply to both income and resources, which must be met before one can qualify for benefits. On the income side, most people do not have a problem qualifying for nursing benefits. One can have an income up to the Medicaid rate of the nursing facility, plus regularly recurring medical expenses, and still qualify for assistance. With COPES, however, as I'll explain below, one's income can often be a bar to one's eligibility for benefits.

As far as resources, a single person is allowed \$2,000 of "countable resources." Exempt resources include: a car worth, in most circumstances, under \$5,000; a home in which the person resides or to which the person intends to return; personal

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- 1 Medicare covers skilled nursing needs only. It requires a minimum three-day prior hospitalization and a coinsurance payment after 20 days of services. (In 2004, Medicare will pay up to \$105/day for days 21 – 100. No coverage is provided after 100 days. In all events, coverage is limited to certain services.)
- 2 Long-term care insurance model regulation and long-term care insurance model act, as promulgated by the National Association of Insurance Commissioners and adopted as of January 1993. The model regulation and act are available through the NAIC website at [www.naic.org](http://www.naic.org) or through the Lexis or Westlaw legal research services.
- 3 A feature that refunds a portion of premiums paid if the policy is canceled or lapses due to nonpayment of premium.
- 4 In addition to the limitations stated above, allowable exclusions include conditions arising from participation in felonious acts; availability of benefits under workers' compensation programs or other liability or occupational disease laws or motor vehicle no-fault laws; services performed by family members; services for which no charge is made in the absence of insurance; dental care, vision or hearing aids, examinations and fittings; rest cures; routine physicals; treatment in government facilities; benefits provided by Medicare; and experimental treatments. WAC 284-54-050(1)-(14).
- 5 See, National Association of Insurance Commissioners, *A Shopper's Guide to Long-term Care Insurance*, for a consumer friendly overview of long-term care insurance. The guide provides a general understanding of possible policy terms and benefits; it does not address specific state laws.

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possessions; burial plots; and life insurance or a burial fund worth under \$1,500 (or, as an alternative to life insurance or a burial fund, an irrevocable pre-paid burial plan or trust). For married couples, the rules are similar, but the home can also be exempt if the spouse resides in it, a car of any value is exempt, and the combined resource limit is \$42,000, though in some cases, as I'll explain in some detail below, the limit can be as high as \$94,760.

When someone receives Medicaid benefits, much of his or her income is usually required to be paid to the provider as the person's "participation" toward the cost of care. One does get to keep a "personal allowance" (of between \$42.62 and \$571, depending which specific program one is on), and limited amounts can also be allocated for a spouse, minor or dependent family members, health insurance premiums, and guardianship costs.

In addition to paying for the specific covered long-term care, Medicaid also provides coverage for most medical expenses such as prescriptions and physician bills. Medicaid is the payer of last resort, however, so it will only pay after Medicare or private insurance has paid its required share.

Aside from the financial tests that must be met, a person must be disabled according to Social Security's criteria in order to receive Medicaid long-term care benefits and must also be found to require the care that is being requested. *See* WAC 388-71-0700.

For a very helpful overview of our state's long-term care Medicaid programs, please visit the Northwest Justice Project's award-winning website, at [http://www.nwjustice.org/law\\_center/healthcare.html](http://www.nwjustice.org/law_center/healthcare.html), and read the very informative overviews published by Columbia Legal Services called, *Questions and Answers on Medicaid for Nursing Home Residents* and *Questions and Answers on the COPES Program*.

### **C. Community Spouse Resource Allocation**

In 1988, as part of The Medicare Catastrophic Coverage Act (Public Law 100-360), Congress passed legislation that required states to allocate limited resources from an institutionalized spouse to a community spouse (i.e., to the spouse not applying for benefits) in the determination of whether the institutionalized spouse satisfied the resource test for Medicaid coverage. This is known as the community spouse resource allocation or, for short, CSRA. Until our Legislature acted last year (passing ESHB 2257, which was signed by the governor on June 26, 2003), Washington allowed spouses the maximum allocation, which, last year, would have been \$90,660. This meant that when one spouse applied for the Medicaid nursing home program or the COPES program, they were allowed, at the time of application, \$92,660—that is, the \$90,660 allocated to the community spouse and the \$2,000 a Medicaid recipient is allowed. Washington's spousal allocation was the maximum allowed under Federal law. (Last year, the minimum allowed under federal law was \$18,132.)

Now, since the enactment of ESHB 2257, the default rule, under WAC 388-513-1350, is a "state spousal resource standard"

of \$40,000. As I'll explain, exceptions, of course, apply.

The broadest exception is that WAC 388-513-1350(6) says that if a "client's current period of institutional status began on or after October 1, 1989 and before August 1, 2003, the department allocates the maximum amount of resources ordinarily allowed by law." So, for clients whose "current period of institutional status" began before August 1, 2003 (but after October 1, 1989), the spousal allocation will still be the maximum, which last year was \$90,660 but now, as of January 1, 2004, is \$92,760. The date of application for benefits will not matter.

What will matter is the date the client's "current period of institutional status" began. WAC 388-513-1320(1) says that to attain institutional status, a client must be "approved for and receiving waived or hospice services" or "reside or be likely to reside in a medical facility for a continuous period of ... thirty days." WAC 388-513-1320(2) provides that a client's institutional status is "not affected by a transfer between medical facilities" or a "change from one kind of long-term care services to another." Finally, WAC 388-513-1320(3) says that a client loses institutional status when the client is "absent from the medical facility for at least thirty consecutive days" or "does not receive waived or hospice services for at least thirty consecutive days."

One important aspect of these provisions is that "institutional status" only attaches if a person is actually *receiving* waived or hospice services. So, in a Catch-22 of sorts, persons applying for waived services (i.e., services paid for under COPES) will not be deemed to have attained "institutional status" until they are actually receiving COPES services.

Further, under WAC 388-500-0005, a medical facility is defined, in part, as a facility that is organized "to provide medical care, including nursing and convalescent care" and that is staffed by "professional personnel." Alternate living facilities, such as adult family homes and assisted living facilities, do *not* fit under this definition. A hospital is considered a medical facility.

So, for example, a client who has privately paid for assisted living from January 1, 2003 through March 1, 2004, and then applies in April 2004 for COPES benefits, will not be eligible to have the pre-August 1, 2003 rules apply to them.

But now to the rule that will apply for most people. According to WAC 388-513-1350, clients whose "current period of institutional status began on or after August 1, 2003" will be allocated the greater of a "spousal share equal to one-half of the couple's combined nonexcluded resources as of the beginning of the current period of institutional status up to the amount described in subsection (6)(a)" or the "state spousal resource standard of forty thousand dollars." The "amount described in subsection (6)(a)" is currently the \$92,760 figure that applies to clients whose institutional status began before August 1, 2003.

Thus, the spousal share for a couple with combined resources of \$185,350 or more can be as high as \$92,760, but not higher, while a couple with resources below \$185,350 will be eligible for

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a lesser allocation only. For example, a couple with combined countable resources of \$150,000 would be entitled to a spousal share of \$75,000. Also, a couple with combined countable resources of \$80,000 or less will not be helped by the spousal share rule; their spousal resource standard will be \$40,000 in any event.

As far as seeking that spousal share treatment, WAC 388-513-1350 (7) provides that the spousal share—that is, half of the couple's combined resources, but not more than \$92,760—can be evaluated “prior to an application for LTC [long-term care] services” or as “as part of the application for LTC services.” In either case, WAC 388-513-1350(7) provides that verification will be necessary. A specific form, called an *HCS Community Resource Declaration*, can be obtained from DSHS to document the previously held resources.

### **D. Trust Rules**

Until August 1, 2003, married couples were able to transfer excess resources, that is, those above the resource limit then in effect, to a certain kind of trust for the community spouse. These trusts were often called “spousal sole benefit trusts” and as long as they met certain requirements, such as paying all trust income and assets back to the community spouse within his or her life expectancy, the assets in the trust were not counted when the other spouse applied for benefits.

However, as of August 1, 2003, under WAC 388-561-0100(5)(e), these trusts are now considered an available resource when determining Medicaid eligibility. While a transfer to such a trust will not result in any period of ineligibility being imposed, the assets in the trust themselves will be considered as available to the institutional spouse, thus defeating any planning advantage to the transfer. There are other planning possibilities available to couples, often involving a conversion of excess resources into an income stream through the purchase of a qualifying immediate, single-premium annuity, but a discussion of such planning is beyond the scope of this article.

The other significant change to the trust rules involves when a person, under 65, can transfer his or her own assets to a trust that is established by a “parent, grandparent, guardian, or the court” and still qualify for Medicaid benefits, even if he or she can later benefit from the trust. These trusts are often called “special needs trusts” or, for a provision in 42 U.S.C. § 1396p(d)(4)(A), “d4A trusts.” The change has to do with the “payback” provision these trusts must have. Such trusts have always required “payback” to Medicaid, at the beneficiary's death, for services provided. Now, under WAC 388-561-0100(7), payback is required not just at death but also at the termination of the trust or at the end of the beneficiary's disability. While there could be some tension raised by this new standard differing from federal Medicaid law, this is the state regulation we have on the books.

One smaller change is that the regulation that governs when a transfer can affect the transferor's eligibility, WAC 388-513-1364, no longer requires that “d4A” trust assets be paid back to the beneficiary within his or her life expectancy. The life expectancy requirement, however, still applies if a third party funds a trust for a disabled child or other disabled person under age 65, and that third party does not want his or her gift to the trust to subject him or her to Medicaid's transfer of asset rules.

### **E. Gifting Rules**

Medicaid has imposed and will continue to impose a period of ineligibility for most gifts made in the three-year period before application. If a trust is involved in the gifting, the period when gifts affect eligibility, the so-called “look back period,” can be five years instead of three. There are many exceptions when the transfer penalty does not apply. I will not be addressing these exceptions here. Instead, I will describe the recent changes that impact how the transfer penalty, for transfers that do count, is calculated.

Under rules that were in effect until April 1, 2003, the period of ineligibility was calculated by dividing (a) the amount given away each month by (b) the average statewide nursing home private pay rate as published by DSHS which, currently, is \$5,204. The result of this division was then *rounded down* to the next whole number, and constituted the number of months of ineligibility caused by the transfers in that month. The period of ineligibility began with the month in which the gift was made, unless that month was subject to a period of ineligibility from a gift in a prior month (in which case the additional period of ineligibility began after the expiration of the prior period of ineligibility). Thus, a gift of \$10,400 would have created only a one-month period of ineligibility ( $\$10,400/\$5,204 = 1.99$ ), and that month was usually the month in which the gift was made. This technique also allowed someone to be on Medicaid and to make monthly gifts of his or her house, without impacting his or her eligibility for benefits, as long as the gifts were less than the \$5,204 figure (or whatever the figure was at the time of the gift).

This all changed on April 1, 2003, as detailed in WAC 388-513-1364. For gifts made on or after that date within the “look back period,” Medicaid now determines the period of ineligibility by the following formula: (a) the total amount of gifts made in any *month* is divided by (b) the average daily cost of nursing home care as calculated by DSHS, which currently is 172, with the result of this division being the number of *days* of ineligibility beginning with the first day of the month (or the expiration of all prior periods of ineligibility). Thus, a gift of \$5,300 will create a 30-day period of ineligibility ( $\$5,300/\$172 = 30.9$ ). The rules also provide that gifts in any month totaling over \$1,000 will impact a person's eligibility. So the ability to be on benefits and at the same time gift away an exempt asset, month by month, is now limited.

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## Avoiding HIPAA Headaches

by Stephen D. Rose, Rose Health Law Group, PLLC\*

By now you have all heard or read about HIPAA, the Health Insurance Portability and Accountability Act of 1996. 42 U.S.C. § 1320d, with associated regulations promulgated at 45 CFR §§ 160-164. The Privacy Rules portion of HIPAA, which is only one small portion of HIPAA (45 CFR Part 164, Subpart E, §164.500-164.534) became effective April 14, 2003. The Privacy Rules are intended to give patients greater access to their healthcare information, allow patients greater control over the flow of their healthcare information, and allow patients to find out who else has had access to their healthcare information. Additionally, given the meteoric rise in the use of electronic communications, HIPAA imposes stringent security measures on how healthcare information is transferred by electronic means.

Given HIPAA's noble purposes, what has happened in the "real world?" In the "real world" HIPAA hysteria took over. Ill-informed "HIPAA consultants" ginned up needless concerns over HIPAA's penalty provisions, warning healthcare providers that if they wrongfully disclosed a patient's protected healthcare information they could be subjected to fines of up to \$250,000 and 10 years' imprisonment. While it is true that these types of draconian penalties do exist for HIPAA violations, in order to be subjected to the \$250,000 fine and/or 10-year imprisonment, one

would have to knowingly obtain or disclose protected healthcare information under false pretenses with the intent to sell, transfer, or use that healthcare information for commercial advantage or personal gain or use the healthcare information with the intent to cause malicious harm. In other words, contrary to the impression that was left with many healthcare providers, the providers could not accidentally stumble into a situation that would land them in jail for up to 10 years; rather they would have to carry out a premeditated effort to obtain and wrongfully distribute health information. 42 U.S.C. § 1320d-6.

The effect of these and other misimpressions on those attempting to obtain healthcare records legitimately from any healthcare provider, while unintentional, has been pronounced. As part of a case I am working on, the State Medical Board investigator assigned to the case told me that she recently had to obtain patient medical records from a major hospital. The medical records were of patients seen by the doctor being investigated. Even though HIPAA should have had no impact on her ability to obtain these records and she should have been provided a copy of the records upon identifying herself as a State Investigator, she spent two full days and had to speak to 16 different people at the hospital before copies of the records she

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### **Recent Changes in Washington's Long-term Care Medicaid Program: More Restrictive Coverage/More Complex Rules**

#### **F. Medically Needy Residential Waiver Program**

Until this year, eligibility for COPES was denied to people whose monthly income was above 300 percent of the federal Supplemental Security benefit rate, which currently would be \$1,692. *See* WAC 388-515-1505(4). While there was a way for couples with combined incomes of \$3,384 or less to qualify, many people who would have benefited from COPES services, either in their own home or in an alternate care facility, such as an adult family home or assisted living facility, instead found themselves receiving nursing home care due to this restrictive rule.

DSHS adopted a new rule on February 6, 2003 that now allows a limited number of people (up to 600) with higher incomes to qualify for COPES care in a facility, but not at home, under a program they are calling the Medically Needy Residential Waiver (MNRW) program. Under this new program, many people with higher incomes are now receiving COPES who otherwise may have been forced to receive care in a nursing home, absent family or other resources to pay for care privately in a facility of choice.

Without going into detail on this, the way the program works, in general terms, is that coverage is available if one's monthly income is more than \$1,692 but less than the COPES rate at the facility plus medical expenses. Thus, someone with \$2,000 of income who resides in a facility where the COPES approved

rate is \$2,300 could qualify for coverage. The regulations on this new program can be found at WAC 388-515-1540.

At the present time, the MNRW program does not cover people who need in-home care. However, I understand that a legislative fix to this situation may (at the time of this writing) be in the works and this fix may, or may not, settle a lawsuit that was brought in the United States District Court for the Western District of Washington to challenge the denial of services to people with higher incomes who required in-home care. The District Court's decision against the plaintiffs in that case, *Townsend v. Quasim*, was recently reversed and the case remanded by the United States Court of Appeals, Ninth Circuit, 328 F.3d 511 (2003).

#### **Conclusion**

Clearly, on the whole, clients are facing more-restrictive Medicaid qualification rules. And, with these restrictions, an already complicated Medicaid program has become even more complicated. As an important policy debate continues regarding how long-term care should be financed and what the role of government should be in that financing, there is going to be a substantial need for attorneys to understand and explain the rules of a program that can be a maze to navigate. I hope this article is an aid to that end.

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## Avoiding HIPAA Headaches

requested were finally provided to her. Under HIPAA, healthcare providers are allowed to forward patient healthcare information to other healthcare providers for treatment purposes without any additional authorization being needed from the patient. Nevertheless, I have dealt with innumerable instances where one healthcare provider refuses to provide that patient's medical records to another healthcare provider who will be treating that patient absent a signed "release" or "consent" form from the patient.

Are all these roadblocks to access to medical records required by HIPAA? Absolutely not. Are these types of demands for additional signed forms routinely made? Absolutely yes.

For an attorney representing a client and drafting Health Care Powers of Attorney or guardianship paperwork and the like, what is HIPAA's impact? For the most part, HIPAA should not impact how you practice. However, the reality is that healthcare providers are much more reluctant to release any medical records for any reason. As a practical matter you have two choices in these circumstances: you can either fight with every medical records custodian you have to deal with until they become more comfortable with the details of HIPAA or you can have your own game plan in place in the hope of avoiding as many headaches as possible by eliminating impediments before they occur.

My recommendation would be to have a three-step process in place that you follow that gradually escalates until you obtain the records you are legitimately requesting. I view the three steps as being: (1) proactive steps you can take now in anticipation of resistance to your being able to appropriately obtain a client's medical records; (2) initial interaction with the healthcare provider; and (3) filing a complaint with the Office of Civil Rights if medical records are improperly withheld.

### Step 1: Be Proactive

There are three aspects to being proactive. The first one is to get educated about HIPAA. You need to learn some HIPAA terminology so that the person you are dealing with does not confuse you with terms you do not understand. Here is a list of some of the terms you might have thrown at you and what their "plain-English" translation is:

HIPAA TERM	COMMON UNDERSTANDING
<b>Covered Entity</b>	Healthcare provider (hospital, doctor's office, doctor, etc.).
<b>Protected Health Information ("PHI")</b>	The patient's medical records you are trying to get.
<b>Individually Identifiable Health Information ("IIHI")</b>	For our purposes, the same thing as PHI.
<b>Privacy Officer</b>	Person you want to talk to at the Covered Entity if you cannot obtain records you have requested.
<b>Office of Civil Rights ("OCR")</b>	Agency with which you would file a complaint if the Covered Entity will not give you the PHI you are requesting and to which you are entitled.

Second, in addition to learning some HIPAA terms, you need to become familiar with a few HIPAA citations that may help you in your discussions with the Covered Entity. For the most part, the HIPAA rules concerning "Personal Representatives" are contained in 45 CFR §164.502 (g). With limited exceptions applicable to unemancipated minors (45 CFR §164.502 (g)(3)) and situations dealing with abuse, neglect, or endangerment (45 CFR §164.502 (g)(5)), "a Covered Entity **must** ... treat a personal representative as the individual." 45 CFR §164.502 (g)(1) (emphasis added). In this context the "individual" is your client, the person whose PHI you are trying to obtain. HIPAA goes on to state: "If under applicable law a person has authority to act on behalf of an individual or an emancipated minor **in making decisions related to health care**, a Covered Entity **must** treat such person as a personal representative ... ." 45 CFR §164.502 (g)(2) (emphasis added).

As I read and interpret the above-cited sections, it seems to me that whatever releases, authorizations, and Powers-of-Attorney you have been using in the past should be sufficient to pass muster under HIPAA and allow you access to your client's medical records, assuming they empower you to act on behalf of your client **in making healthcare-related decisions**. For example, if your forms comply with RCW 7.70.065 as it pertains to representative authority, HIPAA should not negatively impact your ability to obtain your client's medical records. In other words, HIPAA itself should not require a change in your existing forms. However, the manner in which HIPAA is being implemented by healthcare providers may interfere with your access to your client's records. To get around this problem I would recommend adding specific language to your current forms that authorizes the release of PHI to you under HIPAA. I would caption this new paragraph in bold lettering, underline it, and give it a very official-sounding name like, "***Authority for Release of PHI Under HIPAA.***"

You can then craft your own very broad language under this paragraph telling the reader that you are the "Personal Representative" of your client as that term is defined in HIPAA, 45 CFR §164.502 (g), that you are authorized to obtain your client's Protected Health Information ("PHI") or other health information or medical records, that you are authorized to assist your client in making healthcare-related decisions, and that you should be treated as though you are the patient him- or herself for purposes of releasing this information to you. I would also suggest adding some language to the effect that your new paragraph "allows for the release of any information subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320d and 45 CFR §§ 160-164."

As noted above, you will still need to continue to meet the requirements for valid authorizations and the like under Washington state law, but adding the above language, even

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## **Avoiding HIPAA Headaches**

though it may not be technically required, could help pave the way with respect to your dealing with medical records personnel.

Third, the last recommendation I have for being proactive is to visit the OCR website concerning the Privacy Rule: [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa). This is a very user-friendly site full of useful information. If you have difficulty navigating the site, go to the FAQs and type in words to search for particular topics. Odds are you will find numerous questions and answers that will assist you.

### **Step 2: Interaction with the Healthcare Provider**

If you have followed the proactive steps noted above and still are unable to obtain the medical records you seek, tell the medical records clerk that you want to speak with their "Privacy Officer." One of the requirements under HIPAA is that every Covered Entity identify one or more individuals as their "Privacy Officer" or "contact person" who can be contacted in order to address HIPAA issues and complaints. 45 CFR §164.520(b)(1)(vi) and (vii).

You may not be provided with immediate access to the Privacy Officer, but the medical records clerk should provide you with contact information at the very least. Should they refuse to do this, ask for a copy of their Notice of Privacy Practices ("NPP"). Covered Entities must make the NPP available on request. 45 CFR §164.520(c). The NPP should list (usually towards the end) the title and phone number or other contact information for the Privacy Officer. 45 CFR §164.520(b)(1)(vii). If you are refused a copy of the NPP, look around, as HIPAA requires that the Covered Entity's NPP be posted "in a clear and prominent location where it is reasonable to expect individuals seeking service from the covered healthcare provider to be able to read the [NPP]." 45 CFR §164.520(c)(2). If you cannot find where the NPP is posted, go to the Covered Entity's website, if they have one. Pursuant to HIPAA, if a Covered Entity has a website, they **must** post their NPP on the website. 45 CFR §164.520(c)(3). At the web site there will usually be a link entitled "Notice of Privacy Practices" or "Notice of Information Practices." For each of the above steps, keep track of which are not met by the Covered Entity as each one not met constitutes a HIPAA violation which you may eventually report if you go all the way to Step 3.

If you do speak with the HIPAA Privacy Officer, go through the same steps you did with the medical records clerk. Explain your position and the fact that as the personal representative your requests are to be treated as though they came from the patient him- or herself. If that does not work, show the Privacy Officer your authorization focusing on your "Authority for Release of PHI Under HIPAA" paragraph. If even that does not work, go to Step 3.

### **Step 3: Filing a Complaint with OCR**

If all of your efforts to obtain medical information to which you are entitled fail, tell the Privacy Officer that you will go

online to the OCR website and will file a formal complaint against the Covered Entity. Under HIPAA, **anyone** can file a complaint and OCR will act on any complaint filed. 45 CFR §160.306(a). You do not need "standing" such as being the person actually aggrieved by the Covered Entity in order to file the complaint. *Id.* All you have to allege is that you are personally aware of a HIPAA violation. 45 CFR §160.306(b). If the Covered Entity refuses to provide you with the medical records you are entitled to, you are personally aware of a HIPAA violation and are allowed to file the complaint provided that you file your complaint within 180 days of becoming aware of the violation. 45 CFR §160.306(b)(3).

If you have to file a formal complaint in order to obtain the records to which you are entitled, go to [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa) and look for a link titled "How to File a Health Information Privacy Complaint." Click on this link and follow the instructions.

### **Conclusion**

HIPAA has a far reach, and the discussion above is meant only to address one very small area of problems a practitioner could face. This discussion is by no means exhaustive. As with state law, HIPAA provides for special treatment for mental health records, psychotherapy notes, drug and alcohol treatment records, and records concerning some reproductive rights and sexually transmitted diseases. This short article does not address any of these specialty topics, and you should be aware that your right as a personal representative to obtain records pertaining to these matters may be more limited than it is for other records. The information in this article is provided as educational background and not as legal advice. The unique facts of each case should be addressed separately by legal counsel under the applicable provisions of HIPAA and the related regulations as well as state law.

Many of the suggestions listed in this article are not required. However, by being prepared ahead of time and following the above steps, you may save yourself innumerable headaches.

*\* Stephen D. Rose, J.D., M.B.A., is the President of the Rose Health Law Group, a law firm whose practice represents health care providers exclusively. Stephen has been specializing in health law for over twenty years and is a nationally recognized expert on HIPAA. The Rose Health Law Group has provided HIPAA training to its clients and other groups such as the Washington State Medical Association, the Alaska State Hospital and Nursing Home Association, Alaska Regional Hospital, HCA, Valley Hospital, North Star Behavioral Hospital and the Alaska Native Tribal Health Care Consortium. Stephen Rose has also provided HIPAA training to attorneys on behalf of the King County Bar Association, the Washington Law Institute and Western States Health Care Compliance. Mr. Rose can be reached at P.O. Box 13110, Mill Creek, Washington 98082, 425-806-8292 or [stephen@rosehealthlaw.com](mailto:stephen@rosehealthlaw.com).*

## Recent Developments

# Real Property

by Scott B. Osborne, Preston Gates & Ellis LLP, Seattle

Two recent cases decided by the Ninth Circuit Court of Appeals are of interest to real estate practitioners in Washington. The first case, which resulted in two opinions, *Keystone Land & Development v. Xerox Corporation*, 353 F.3d 1070, 2003 U.S. App. LEXIS 26462 (9<sup>th</sup> Cir. 2003), and a companion opinion, *Keystone Land & Development v. Xerox Corporation*, 353 F.3d 1093, 2003 U.S. App. LEXIS 26463 (9<sup>th</sup> Cir. 2003), involved litigation arising out of a letter of intent. The second case, *Redback Networks, Inc., v. Mayan Networks Corp. (In re Mayan Networks Corp.)*, 2004 Bankr. LEXIS 184 (Bankr. Panel 9<sup>th</sup> Cir. 2004), involved an attempt to retain a letter of credit given as a lease deposit by a bankrupt tenant.

*Keystone, supra*, arose from a common sequence of events in a proposed sale of real estate. Xerox owned a commercial building in Tukwila, Washington. Xerox engaged two brokerage firms to sell the property as part of a sale-leaseback transaction. The brokers prepared offering packages describing the property, which were then sent to prospective buyers, including Keystone Land & Development Company. The offering packages solicited responses in the form of a "signed Letter of Intent which includes the net purchase price and key deal points." *Id.* at 1073.

Keystone responded through its broker. The initial letter response had several contingencies, including the execution of a purchase and sale agreement within thirty days following the full execution of the letter of intent by both buyer and seller. Xerox's broker replied to the initial letter seeking clarification of certain points. Keystone responded by increasing the proposed purchase price. Xerox's brokers responded again, stating that, subject to two changes in the offer,

"... Xerox was 'prepared to negotiate a Purchase and Sale Agreement with Keystone,' and that Xerox would 'proceed immediately to draft' the Agreement if Keystone would accept the modifications. Keystone accepted the modifications ..." *Id.*

As due diligence proceeded, Xerox became concerned that Keystone would not be able to finance the acquisition. Xerox requested assurances from Keystone's lender that there was a commitment for financing, but "[f]aced with vague answers given by an officer of Key Bank, Keystone's financier, Xerox became concerned about Keystone's suitability as purchaser and landlord." *Id.* at 1074. Twelve days after Keystone had accepted Xerox's additional conditions to the sale, Xerox received an offer from the City of Tukwila to buy the building for \$500,000 more than Keystone had offered. Xerox accepted that offer, and no further negotiations were conducted with Keystone.

Keystone fielded an action to enforce what it claimed was an agreement to sell the property and filed a *lis pendens* against the property. Xerox removed the case to U.S. District Court. After

Xerox counterclaimed for damages, the *lis pendens* was released. The trial court dismissed the Keystone complaint on a motion for summary judgment, and also awarded attorneys' fees based upon a wrongful filing of the *lis pendens*.

On appeal, the judgment dismissing the Keystone claim was affirmed. The court noted that although it was possible under Washington law to enter into a contract even in contemplation of a more formal agreement, whether or not Keystone and Xerox intended that result in this case was a question of the intent of the parties. Viewing the exchange of letters in a light most favorable to Keystone, the court concluded that no rational trier of fact could conclude that the parties intended the letters to constitute a binding agreement. This was true, even though the letters did not include the normal disclaimer found in letters of intent that the parties were not binding themselves until a formal purchase agreement was drafted. The letters did, however, clearly contemplate a final purchase agreement to be drafted, and there was no intent for the parties to be contractually bound until that agreement had been drafted and executed.

The court did reverse the judgment against Keystone based on the filing of the *lis pendens*. The court noted that under RCW 4.28.328, imposition of damages and attorneys fees was not automatic if there was substantial justification for filing the *lis pendens*. In this case, Keystone was in fact making a claim affecting the title to the property, and even though the claim was not meritorious, Keystone had substantial justification in filing the action. If an agreement to sell the property had been established, Keystone could have asserted an estoppel argument to avoid the further defense of the statute of frauds, so the court was unwilling to conclude that Keystone's claim had no substantial justification. This result is probably justified under RCW 4.28.328, particularly in light of the different treatment of damage claims for filing a *lis pendens* in an action not related to a claim affecting title versus a claim that does in fact relate to the title to real property (*compare* RCW 4.28.328(2) *with* RCW 4.28.328(3)).

In the companion *Keystone* case, the court confronted the remaining issue of whether Washington law recognizes a claim based on a breach of an agreement to negotiate. The trial court had dismissed this claim asserted by Keystone against Xerox. Although the court takes a brief journey through Washington case law dealing with the duty of good faith and fair dealing and whether an agreement to agree is enforceable under Washington law, the court ultimately determined that it was unable to articulate Washington law on this topic. The court certified two questions to the Washington State Supreme Court—first, does Washington contract law recognize and enforce an agreement to negotiate a future agreement and second, if Washington does recognize and

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### **Recent Developments: Real Property**

enforce an agreement to negotiate, what are the damages in the event the agreement is breached? The answers to these questions will have to await a response from the Washington State Supreme Court.

*In re Mayan, supra*, dealt with the so-called “cap” on damages under §502(b)(6) of the United States Bankruptcy Code. Mayan, the bankrupt debtor, was a sublessee of space in a large commercial building. Mayan had given the landlord a cash security deposit of \$351,033 and a letter of credit in the amount of \$648,966. The letter of credit was secured by \$650,000 in cash deposited by Mayan with the issuing bank.

Mayan rejected the sublease, and it was agreed that the damages to the landlord were \$1,701,535, which was computed by adding pre-petition unpaid rent to one year’s rental amount (§502(b)(6) caps liability for lease rejection damages at the greater of one year’s rent or 15% of the remaining rental amount, not to exceed three years’ rent). The Bankruptcy Court reduced that claim by the amount of the cash deposit, plus the amount of the letter of credit. The landlord asserted that the amount of the letter of credit should not be applied to reduce the unsecured damage claim. Apparently, the landlord believed that the bankruptcy would produce some payment allocable to the unsecured damage claim.

The Court rejected the landlord’s claim that the letter of credit should not reduce the unsecured claim for rejection damages because the letter of credit was not property of the bankrupt estate, but an independent obligation of the issuing bank. This argument ignored the plain language of the “cap” provision of the Code. The provisions of §502(b)(6) do not differentiate as to who pays the damages to the landlord, but represents an absolute limitation on the amount the landlord can recover from the bankrupt. The relevant consideration was whether ultimately property of the estate would be used to pay the landlord. Since the letter of credit was backed by a cash deposit belonging to Mayan, this property was in effect used to pay the landlord.

The court did, however, point out the difference between the situation in which the bankrupt’s funds were ultimately used and a true third-party guarantor delivered a letter of credit to secure the performance of the lease. In the latter case, the letter of credit proceeds would not be used to offset the capped claim of the landlord. As noted by the concurring opinion, which includes a thorough discussion of all of the relevant case law on the treatment of letters of credit in tenant bankruptcies:

One crucial consequence of the analysis is, however, that if the security deposit is not property of the estate because it was provided by somebody else . . . and is refundable to that person, then the result is probably different. If the estate has no claim on the security deposit, then the security deposit is more in the nature of a mere guaranty and ought to have no effect on the §502(b)(6) cap . . . . The bottom line is that landlords are permitted to obtain credit enhancements that will net them more than the §502(b)(6) cap, but only so long as the excess does not come from property of the estate.

*In re Mayan, supra*.

Not addressed in the opinion is the validity of attempting to divide a tenant’s obligations into two or more distinct parts in an attempt to avoid the effect of the cap. It is not uncommon for landlords to create a separate obligation to repay tenant improvement advances, or some other obligation rather than “rent” under the lease. This separate obligation is secured with a letter of credit, or other security device. Arguably, since this is not a rental obligation that is subject to the cap, the security for this obligation, when combined with the lease security deposit, can exceed the cap and be retained by the landlord. The emphasis of the court as to whether the ultimate source of the funds was the bankrupt’s estate may create further arguments for bankrupt tenants that these types of arrangements should be disregarded and the §502(b)(6) cap applied to all sums due with respect to the lease.

## Recent Developments

# Probate and Trust

by Colonel F. Betz, Perkins Coie LLP, Seattle

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### WASHINGTON COURT OF APPEALS, DIVISION II

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*Niemann v. Vaughn Community Church*, 118 Wn. App. 824 (Oct. 2003)

**Summary:** Deed language, which established a charitable trust, constituted a discriminatory restraint on alienation of the property prohibited by statute, and the equitable doctrines of cy pres and equitable deviation applied to permit a church to sell the property.

**Facts:** In 1956, the Board of Trustees of the Emanuel Congregational Church of Vaughn conveyed its church property to the Vaughn Community Church of Christ (“VCC”), with the stipulation that VCC have and hold “said property for the perpetual use of Protestant Evangelical Churches of the Community of Vaughn, Washington.” This language created a charitable trust.

In 1991, VCC determined that to accommodate necessary growth, the church property must be sold on the open market and new facilities built within a five to fifteen minute drive from the current location.

Niemann, a long-time VCC member, sought to enjoin the sale by enforcing the deed language. VCC counterclaimed for equitable remedies that would enable it to sell the property.

**Discussion:** RCW 49.60.224 provides that “[e]very provision in a written instrument relating to real property which purports to forbid or restrict the conveyance...thereof to individuals of a specified...class...is void.” Niemann presented both constitutional challenges and statutory interpretation questions.

Niemann argued that the Washington Constitution and the First Amendment to the United States Constitution protected “a charitable gift of property by a church to the Protestant Evangelical Churches of a particular community.” The court held that while Niemann has standing as someone with a special interest in the enforcement of the trust, the issue deals with the gift-giver’s rights. Niemann does not have standing to assert the trust settlor’s constitutional rights pertaining to the establishment of the trust.

Next, Niemann argued that invalidating the deed language based upon RCW 49.60.224 would result in an unconstitutional burden on her freedom of religion. The court held that a law does not unconstitutionally burden one’s freedom of religion if the law (1) does not have a coercive effect in the practice of religion or (2) effectuates a compelling state interest by the least restrictive means. Because the statute is narrowly tailored to the stated goal (invalidating discriminatory restraints on alienation), RCW 49.60.224 does not impermissibly burden the freedom of religion.

The court also rejected Niemann’s argument that the statute, which was enacted after the 1956 deed, should not apply retroactively. The presumption is that a statute will only apply prospectively, unless (1) there is legislative intent to apply the law retroactively, or (2) the statute is remedial and retroactive application would further its remedial purpose. Citing language

from the statute itself and controlling case law, the court concluded Chapter 49.60 RCW is a remedial statute and retroactive application would further its remedial purpose.

Niemann’s final statutory argument focused on the limited protected class of RCW 49.60.224. The court agreed with VCC that the deed language forbids sales to many different people, even many who fall within the classes protected by RCW 49.60.224. Therefore, the statute applies and mandates that the restrictive deed language be void.

The court, in summarizing the constitutional and statutory interpretation questions, concluded that the trial court properly removed the discriminatory restraint on alienation from VCC’s deed, and correctly decided that VCC could sell the property to any person or entity without regard to the deed restrictions.

Niemann also appealed the trial court’s application of the equitable relief doctrines of cy pres and equitable deviation. Because a trial court holds broad discretionary power to fashion equitable remedies, its decision was reviewed for abuse of discretion.

When analyzing the equitable remedy, the first step is identifying the parties, their powers and the controlling intent. As the deed grantor, Emanuel Congregational Church of Vaughn is the trust settlor. While VCC is the primary beneficiary, the community of Vaughn is the class of beneficiaries. The trial court record establishes that the settlor’s dominant intent was to benefit the new church, VCC, and to provide for its success, growth, and the endurance as a church, in ministering and spreading the gospel to the Protestants of the Vaughn Community, regardless of where the ministries were specifically located.

Equitable deviation allows a trustee of a charitable trust to deviate from a term of the trust if compliance is impossible or illegal, or if owing to circumstances not known to the settlor and not anticipated by him compliance would defeat or substantially impair the accomplishment of the purposes of the trust.

The doctrine of cy pres provides that “[i]f...it is or becomes...impracticable...to carry out the [intended] purpose, and if the settlor manifested a more general intention to devote the property to charitable purposes, the trust will not fail but the court will direct the application of the property to some charitable purpose which falls within the general charitable intention of the settlor.”

Because the settlor had a broad, general charitable intent, and the location of the church, coupled with the need for growth, supports the basis for concluding that continued use of the property is impracticable, the court found that the doctrines of cy pres and equitable deviation were applicable. Thus, the trial court did not err in entering the challenged findings, and the findings supported the challenged conclusions as to the intent of the trust and the application of the equitable doctrines.

## Notes from the Chair

by Thomas M. Culbertson, Lukins & Annis, P.S., Spokane –  
Chair, Real Property, Probate & Trust Section

At the midyear meeting in June at the Skamania Lodge, we will elect new members to the RPPT Executive Committee as well as a new Director of the Probate & Trust Council. The official notice is elsewhere in this newsletter. Mary Anne Vance and Jennifer King, on the probate and trust side, and Vincent DePillis and Michael Barrett, on the real property side, have graciously agreed to serve two-year terms on this important committee. Al Falk, who is just completing his two-year term, has agreed to serve as Director of the Probate & Trust Council, which means that over the next several years he will work his way up to chair of the Section. All of this, of course, is subject to your confirming vote at the mid-year meeting. Previously confirmed and moving into new positions will be Bill Reetz as chair and Lora Brown as chair-elect. All of these individuals have already contributed significantly to the well-being of the Section, and we look forward to, and greatly appreciate, their continued involvement.

Unusual events seem to occur in bunches, and over the last few months the Section has received three requests to file amicus briefs. As I reported in an earlier newsletter, at the recommendation of the Executive Committee the WSBA has filed a brief in the case of *In re Jones*, 116 Wn. App. 353 (2003), but the Committee has declined to participate in the other two appeals. As a practical matter, there are two significant criteria which must be satisfied for the Executive Committee to take action in an appeal: Is there a consensus on the Committee that the decision below was wrongly decided, and is someone independent from the parties able and willing to prepare the brief? Technically, the criteria and procedures adopted by the WSBA are a little more sophisticated, requiring at a minimum that the appeal raise an issue of widespread interest. Although most requests to file an amicus brief come first to a Section, it is actually the Board of Governors which makes the final decision, and the brief is filed in the name of the WSBA,

not the Section. The Board of Governors has appointed an amicus committee, which reviews all requests and makes its recommendation to the Board. Given the procedural requirements, the intensive *pro bono* work required to prepare and file a brief, and the short timetable within which these requests usually arise, it is not surprising that amicus briefs are infrequently filed by the WSBA.

Members of the Section have, as usual, been very busy on the legislative front, with two efforts worthy of particular mention. Vince DePillis, Dave Rockwell, and Gary Ackerman have spent many, many hours trying to ensure that the opposing views of condominium developers and consumer advocates yield legislation which accomplishes its intended effect. As of this writing (early March), we do not yet know the outcome of that legislation. Mike Carrico and Dean Butler, with the endorsement of both this Section and the Taxation Law Section, have similarly spent many hours working with the Department of Revenue and others trying to remedy some of the difficult and unintended results arising out of the de-coupling of the Washington estate tax from the comparable federal tax. Unfortunately, two bills which we felt would have been very good for practitioners and their clients, and which had the support of the Department of Revenue, both died, the victims of much larger political issues swirling around the estate tax. All of these individuals deserve our thanks for their efforts on behalf of all of us.

Finally, the last several times the midyear meeting has been held at the Skamania Lodge we have sold out our block of allotted rooms, and we do not anticipate this year being any different. The resort's location in the beautiful Columbia Gorge is always a big attraction, and our seminar co-chairs, Tim Burkhart and George Ferrell, are putting together another outstanding program. The dates are June 4 through 6, and it is not too early to make your reservations. We look forward to seeing you there.

## Nominations for Executive Committee Membership

### Pursuant to the Bylaws of the Real Property, Probate & Trust Section

The Nominating Committee, currently composed of Mark W. Roberts of Preston Gates & Ellis LLP (Seattle); Barbara C. Sherland of Stoel Rives LLP (Seattle); and Serena S. Carlsen of Stoel Rives LLP (Seattle), has recommended the nomination and election of the following persons to the offices indicated for the 2004-2005 term of the Real Property, Probate & Trust Section:

#### Director, Probate & Trust Council

*Alfred M. Falk* – Harlowe & Hitt LLP (Tacoma)

#### Real Property Council

*Vincent B. DePillis* – Real Property Law Group (Seattle)

*Michael A. Barrett* – Perkins Coie LLP (Seattle)

#### Probate & Trust Council

*Jennifer L. King* – Davis Wright Tremaine LLP (Seattle)

*Mary Anne Vance* – The Law Office of Mary Anne Vance, P.S. (Seattle)

Pursuant to the Bylaws, William H. Reetz of LandAmerica Financial Group (Seattle) will become chair of the Section for the 2004-2005 term and Lora L. Brown of Stokes Lawrence, P.S. (Seattle) will become chair-elect.

Any additional nominations should be received by the current Chair, Thomas M. Culbertson of Lukins & Annis, P.S., 717 West Sprague Ave., Suite 1600, Spokane, Washington 99201-0466, no later than 20 days before the annual meeting which will be held during the Real Property, Probate & Trust Section Midyear Meeting scheduled for June 4-6, 2004, at Skamania Lodge, Stevenson, Washington. Nominations must include the name of the person to be nominated and written endorsement by five members of the Real Property, Probate & Trust Section.

Unless additional nominations are received, the persons nominated by the Nominating Committee shall be deemed elected.

## Midyear Meeting News

The Midyear Meeting for the Real Property, Probate & Trust Section will be held June 4th through 6th at Skamania Lodge, Stevenson, Washington. Seminar co-chairs Tim Burkhart and George Ferrell are putting together an outstanding array of programs that will have something for everyone. There will also be the usual opportunities to see old friends and make new ones at this beautiful location in the Columbia Gorge. We expect that our block of allotted rooms will sell out before the meeting, so make your plans now to join us at Skamania. You can contact the Lodge at 1-800-221-7117 or 509-427-7700. The website for the lodge can be found at <http://skamanielodge.dolce.com>. Please note that dinner reservations are required for Friday night in the Cascade Dining Room, so you may want to make dinner reservations when you reserve a guestroom.

### SERVICE CENTER... AT YOUR SERVICE!

**800-945-WSBA** or **206-443-WSBA**  
*questions@wsba.org*

We're here to serve you!

The mission of the WSBA Service Center is to respond promptly to questions and requests for information from our members and the public.

Call us Monday through Friday, from 8:00 a.m. to 5:00 p.m., or e-mail us at *questions@wsba.org*.

Assistance is only a phone call or an e-mail away.

## INFORMATION FOR YOUR CLIENTS

Did you know that easy-to-understand pamphlets on a wide variety of legal topics are available from the WSBA? For a very low cost, you can provide your clients with helpful information. Pamphlets cover a wide range of topics:

- Alternatives to Court
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- Lawyers' Fund for Client Protection
- Legal Fees
- Marriage
- The Parenting Act
- Probate
- Real Estate
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- Signing Documents
- Trusts
- Wills

Each topic is sold separately. Pamphlets are \$9 for 25, \$15 for 50, \$20 for 75, and \$25 for 100. Pricing for larger quantities is available on request.

To place your order or for more information, please contact the WSBA Service Center at 800-945-WSBA or 206-443-WSBA. Sales tax is applicable to all in-state orders.

## CLE Credits for Pro Bono Work?

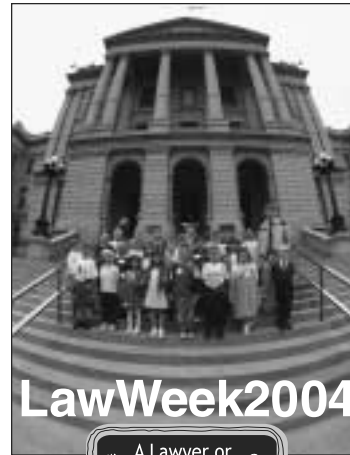
### Limited License to Practice with No MCLE Requirements?

Yes, it's possible!

Regulation 103(g) of the Washington State Board of Continuing Legal Education allows WSBA members to earn up to six (6) hours of credit annually for providing *pro bono* direct representation under the auspices of a qualified legal services provider.

APR 8(e) creates a limited license status of Emeritus for attorneys otherwise retired from the practice of law, to practice *pro bono* legal services through a qualified legal services organization.

For further information contact Sharlene Steele, WSBA Access to Justice Liaison, at 206-727-8262 or [sharlene@wsba.org](mailto:sharlene@wsba.org).



### April 26-30

**Law Week 2004** is just around the corner. Each spring, hundreds of Washington lawyers and judges visit classrooms in their communities to educate students about law, civics, the justice system, and democracy.

For more information about volunteering, visit the Law Week website at [www.lawweek.org](http://www.lawweek.org). The website offers sign-up forms, lesson plans, and other collateral materials to help with your presentation. You can also request more information by emailing [lawweek@wsba.org](mailto:lawweek@wsba.org) or calling 206-239-2117.

## Join Today!

The officers of the Real Property, Probate & Trust Section urge you to become an active member of this important section. All members of the Washington State Bar Association are eligible. Simply fill out the form below and mail with a check for \$15 to:

**Real Property, Probate & Trust Section, Washington State Bar Association,  
2101 Fourth Avenue, Suite 400, Seattle, WA 98121-2330**

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Please enroll me as an active member of the Real Property, Probate & Trust Section. My \$15 annual dues are enclosed.

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