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How Plan Administrators Should Assess and React to a Plan Participant with Diminished Mental Capacity

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This article highlights the legal framework within which individuals can voluntarily name agents to make decisions on their behalf if they should no longer retain the required level of mental capacity needed to make legally binding decisions, or a local court will appoint a guardian to mandatorily make such decisions. The article serves two purposes. First, as the reader is either a pension administrator or consultant, it highlights how agents or guardians can present themselves as surrogate decision makers for plan participants or beneficiaries and how the plan administrator can verify the legal effect, and parameters of, such a surrogate. The first section highlights how plan administrators

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can recognize possible problems with proper mental capacity when they deal with a plan participant or beneficiary; the second section highlights how agents or guardians can present themselves as surrogate decision makers for plan participants or beneficiaries, and how the plan administrator can verify the legal effect of and parameters of such surrogate; the third section briefly explains the professional responsibility measures already in place for attorneys when they represent a client with diminished capacity; and, taking those professional responsibilities already proscribed to attorneys, the conclusion opines that all professional associations (including those to which most plan administrators or consultants belong) should reevaluate their internal standards of professionalism, with an eye toward adding a rule that specifically deals with clients or members who have diminished capacity. And as each reader will age and possibly lose some mental capacity, the second purpose of this article is to highlight the importance of personal and familial planning for individual property.

In the life cycle of being a participant in a qualified plan (or any other type of employee benefit plan), many decisions need to be made. The normal procedure is that the plan administrator provides enough information (most likely written in a manner that is calculated to be understood by the average plan participant) to the participant to make such a decision as:

- Who should be named as a beneficiary;
- How much should be deferred from salary as a 401(k) contribution;
- How the 401(k) plan account should be invested; and
- What optional form of benefit should be selected.

The participant then communicates a response, and the plan administrator follows those instructions. Inherent in the idea of communication is that the participant actually understands the choices available and the positive and negative consequences of a decision, and that the participant then has the mental capacity to formulate a decision and to communicate the decision back to the plan administrator.

However, as our society—and as a consequence, our labor force—is aging, and as there is a correlation between aging and diminishing mental capacity, plan administrators need to prepare for more and more plan participants, or their plan beneficiaries, to lose the capacity to make decisions on their own. (For now, please realize that although the individual likely will have stopped working if he or she lacks basic mental capacity and might actually be on disability, that individual might still be a participant in the plan, needing to make and communicate decisions.) In addition, for the readers who are

consultants, the average age of small business owners is increasing, and without admitting it to themselves, you might meet with a business owner who, in your untrained opinion, lacks adequate mental capacity. In the United States, only adults with a minimal level of mental capacity can make legally binding decisions, and if any individual is, or is perceived as, lacking mental capacity, then a surrogate decision maker must make decisions on that adult's behalf.

This article is written in the form of an essay, with general statements and few citations. It is meant to educate plan administrators and consultants about issues that will need to be resolved when they deal with either a participant or beneficiary lacking mental capacity, or a surrogate who claims to have the authority to make decisions on that participant's behalf. This article highlights the legal framework within which individuals can voluntarily name agents to make decisions on their behalf if they should no longer retain the required level of mental capacity needed to make legally binding decisions, or a local court will appoint a guardian to mandatorily make such decisions. Citations are provided, where necessary, to guide you to more technical rules. However, since elder law issues and resolutions are defined on a state-by-state basis, this article is kept at a general level.

RECOGNIZING DIMINISHED CAPACITY

As plan administrators and consultants, when drafting summary plan descriptions (SPDs) and other required notices, we are already supposed to be getting into the minds of the plan participants and beneficiaries, since most communications are either statutorily or through regulations required to be written in a manner calculated to be understood by the average plan participant. Assuming complete compliance, there is still the left-tail of an imaginary normal curve where some actual plan participants will not understand the communication. When those individuals need to make decisions about the plan, it might take more time and effort on the part of the plan administrator to communicate to the participant in a different manner so that he or she understands the choices available and the consequences of each decision. Ideally, this alternate explanation will allow the participant to communicate a decision. As long as adequate information was provided to the plan participant, and as long as he or she had adequate mental capacity to understand, formulate, and communicate a decision, then that decision is legally binding. The plan administrator has a fiduciary duty (under ERISA) to implement the decision, even if the decision is harmful to the participant. For now, let's assume the participant chooses to invest 100 percent of his or her 401(k) account balance in a risky international growth fund.

The group of employees described above generally will have less education than the average plan participant, and the extra time and effort on

behalf of the plan administrator is needed to attempt to describe the plan and its associated choices in a more understandable manner. Those plan participants are obviously good employees, doing their assigned jobs properly and adding utility to the employer; as such, they are rewarded by participating in the plan. But do we, as plan administrators or consultants, take the same extra time and effort for an individual who, based on education level, should be at least an "average" plan participant or even an above-average participant, but at this time, whether due to an actual accident or disease or just due to aging, has diminished mental capacity? My fear is that the answer is "no"; however, my hope is that after we educate ourselves to recognize signs of diminished mental capacity, we can either communicate differently with these plan participants (maybe we need to talk slower and louder, and find the time of day when they are most alert and aware, and so we do not need to simplify our style of communication in any other manner). As explained later in this article, this requirement for finding alternate methods of communication is mandatory for all attorneys who have, or are suspected to have, clients with diminished capacity (and as the conclusion offers, perhaps other professionals and professional associations will follow suit).

> The functional activity at the heart of mental capacity is the ability to make and communicate decisions with respect to whatever particular legal task is at hand. Capacity is task specific and time specific, and despite continuous striving by the mental health professions for objectivity and consensus, no universal definition of decision making capacity exists. Nevertheless, the basic parameters of decision making capacity can be described. Perhaps the clearest and most enduring articulation remains that of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, enunciated in their seminal 1982 report: Decisionmaking capacity requires, to greater or lesser degree: (1) possession of a set of values and goals; (2) the ability to communicate and to understand information; and (3) the ability to reason and to deliberate about one's choices.[1]

The bottom line is that attorneys need to make these initial determinations, and the great majority of attorneys have never been trained in psychology or any other type of clinical medicine. The exact rules, which are explained later in this article, only require the attorney to do the following:

- Make an assessment that the client has full mental capacity and can therefore maintain a normal attorney–client relationship;
- Make an assessment that the client, by all reasonable and objective standards, wholly lacks mental capacity, and can no longer take actions on his or her own behalf; or

- Refer the client to a psychologist or other professional who is trained to make a true assessment if there is any doubt as to the client's full mental capacity.

Although there are no legally sanctioned methods offered to attorneys in making assessments, a collaboration between the American Bar Association and the American Psychological Association produced three books that arguably, if followed, will at least protect the attorney from disbarment or a malpractice liability.[2]

The argument made here is that by understanding, at a basic level, the concept of mental capacity, a plan administrator or consultant can talk to an individual and assess adequate competency or insufficient capacity. However, those are the two ends of the competency spectrum. If the plan administrator recognizes that there might be a question as to whether the participant has full mental capacity, then hopefully the plan administrator or consultant will have a procedure in place for suggesting to the individual that he or she go for a mental capacity test (which, unfortunately, might be quite insulting to that individual).

SURROGATE DECISION MAKERS

Basically, all adults (that is, individuals who have attained the age of majority, which is 18 in most states, and who are not at that time diagnosed with a mental illness or disability) are assumed to have full mental capacity and, therefore, are assumed to have the ability and capacity to make decisions over their property and over their health and bodies. The US legal system generally does not interfere with these private decisions and allows adults to make decisions, even if those decisions cause harm to that individual (or possibly to some other individuals, such as children who will ultimately inherit less money because mom just donated half of her checking account to her church). However, the US legal system requires a surrogate decision maker to step in and make decisions for individuals who lack capacity or who have diminished capacity due to aging.

Whenever an interested party (such as a child) thinks that an individual lacks the mental capacity needed to make good decisions, or at least to understand the consequences of ill-advised or harmful decisions, then all states have laws in place that allow local courts to make a final determination. If the judge agrees with the plaintiff and classifies the individual as "incapacitated," a "disabled adult," or whatever term of art is used in a particular state, then a "guardian" or "conservator" will officially be appointed by the judge through a binding court order. However, each "capable" individual has the right and opportunity to voluntarily name a trusted person as agent through a

durable power of attorney (DPOA) contract. If done properly, this action avoids an adult guardianship trial.

Mental incapacity can be due to an intellectual or mental impairment from birth or before becoming an adult, to a specific brain injury or disease after becoming an adult, or to gradual impairment as a person ages. Under individual state laws, adults generally have the ability to do some planning earlier in life, while they have full mental capacity, so that their wishes will be upheld later in life, when they have lost their capacity. Basically, the main planning tool for decisions over property is a DPOA for property.

Agents under Durable Powers of Attorney Contracts

Each state has its own rules for DPOAs, and in many states, there is a separate form and separate set of rules for DPOA for property or for health.[3] Both are voluntary contracts, in which the principal (that is, the individual who is doing the planning) names an agent (that is, any other person, who could be a family member, friend, or professional), sets out the parameters of the agent's decision-making authority, and describes the future date or event upon which the agent's authority vests. Each state has specific rules, such as how many witnesses are needed; whether signatures need to be notarized; whether the agent can name a successor agent; and whether, by executing this current DPOA form, all previously executed DPOA forms are revoked. Although state statutes absolutely govern the enforceability of DPOAs executed and exercised within that state, most states also have statutes that encourage third parties within that state to honor DPOAs executed in another state.

What Authority Can an Agent Exercise?

As to the authority the agent will eventually have under the DPOA for property, most states have boilerplate language that lists, in general terms, basic property transactions, such as conveyance of title for real estate, use of checking accounts, business operations, tax matters, and investments. In addition to the list of transactions, most state DPOA for property forms also include a final item on the list, such as "all other property transactions."[4] Depending on the boilerplate language of a state's DPOA statutory form, and depending on any individual DPOA contract with limitations, exclusions, or additions to the agent's authority inserted by the principal, if effective, the plan administrator should be able to determine whether the DPOA allows communication with the agent on behalf of the plan participant or beneficiary.

When Does the Agent's Authority Become Effective?

As to the event that vests the authority in the agent, there are many potential legal and logistical problems. Remember, the purpose of this

advanced planning instrument is for the principal, while he or she has the mental capacity to make decisions over his or her property, to name the individual who will make those decisions later in life. But what is the exact event by which third parties (banks, real estate agents, plan administrators) will know that the agent has the legal authority to receive information and make decisions on behalf of the principal? Most state's statutory forms are simply blank, and ask the principal to insert a future date or event that will vest the authority in the agent, some with suggestions. So either the principal, if completing the form without the assistance of an attorney, or the attorney who has experience, will put into words the event that the principal envisions. Simply putting the words "when the principal no longer has the mental capacity necessary to make and communicate decisions over his or her property" will generally not be enough. What is the proof?

So, some will state an event such as "when a licensed physician puts in writing that the principal no longer has the mental capacity necessary to make and communicate decisions over his or her property." This is good, as long as the agent does not desire the authority as soon as possible, so that he or she can exploit the principal's property. Unfortunately, as I tell my elder-law students, although there are perfectly happy families out there in which even the thought of elderly abuse or financial exploitation brings discomfort, those are not the families that make the newspapers or court cases. All data suggest that children named as agents on a DPOA for property, who have their own creditor problems (including drug and gambling problems), are more likely to exploit the principal's property for their own use. The children could fraudulently prepare a DPOA with a forged signature of the principal and purposely insert a loose event like this, or when presented with a legitimate DPOA that has a loose and easy event like this, realize how easy it would be to exploit the parent.

So, the event should be a little harder to satisfy. However, if fear of exploitation drives the principal to the other end of the spectrum, the event might be too specific and too difficult to achieve, such as "only upon the written opinion of Dr. David E. Morse that the principal no longer has the mental capacity necessary to make and communicate decisions over his or her property." Okay, Dr. Morse (no relation to the editor-in-chief of this journal) might have been the principal's primary care physician for the last 30 years, and the principal is sure that he would not provide a written comment that the principal has diminished capacity simply because her son, named as agent, asks him to do so. The problem here is that if Dr. Morse cannot make this determination (for example, he has died, he has retired, or the principal was travelling to another state and could not physically be examined by this particular doctor),

then the agent's authority will never vest, even if in reality the principal has lost the requisite mental capacity to make decisions over his or her property.

By now you should realize that there is no right answer. Somewhere in the middle are such events as:

- "only upon the written opinion of Dr. David E. Morse, if he is still practicing, or if not, then the written opinion of any licensed physician who has examined the principal while he or she had complete mental capacity, that the principal no longer has the mental capacity necessary to make and communicate decisions over his or her property,"

- "only upon the written opinion of Dr. David E. Morse, or upon the concurrent written opinions of two licensed physicians who do not share the same practice, that the principal no longer has the mental capacity necessary to make and communicate decisions over his or her property," or

- "only upon the concurrent written opinions of a licensed physician and a licensed social worker that the principal no longer has the mental capacity necessary to make and communicate decisions over his or her property."

There is no magic event that fits all principals in all situations in all states.

If you are a plan administrator, even if you determine that a piece of paper purporting to be a valid DPOA for property is actually valid, you must read the words describing the "springing" event carefully, and make certain that any accompanying written opinions match the people who, under this voluntary contract, are the proper individuals to assess the principal's capacity. There are no regulations on this aspect of plan administration, but we can steal a bit from a determination as to whether a piece of paper purporting to be a qualified domestic relations order (QDRO) is a valid QDRO. As long as care is exercised in the determination, and as long as you do not have reason to believe otherwise, there is most likely no need to perform an extensive investigation. On the other hand, if the plan has easy and reasonable access to legal counsel, then there is nothing wrong with getting a legal opinion as to the legal effect of a DPOA. And, taking this article further, in your role as an individual, if you decide to do some advanced planning and become a principal on a voluntary DPOA form, please think about the words you choose to use.

Connected with the effective date of a DPOA for property contract, there is generally no termination date, unless the contract states an actual termination date. Under English common law (as it

was imported to the original English Colonies), power of attorney contracts automatically terminated upon either the death of the principal or upon the incapacity of the principal. Hence, these DPOA contracts, which are described and detailed by various state laws, are specifically meant to endure periods of incapacity of the principal.

DPOA contracts will always terminate upon the principal's death, but will generally continue to be effective during periods of the principal's incapacity. As discussed, if the loss of mental capacity is directly caused by the principal's advancing age (as opposed to an actual brain injury or medically ameliorable mental illness), the original determination that the principal has lost capacity to continue making decisions over property will usually not be reversed. However, if the principal wants to insert an event reversing the effective date, then care on the exact wording should similarly be taken for the date or event that divests the agent's authority.

HOW SHOULD THE AGENT MAKE DECISIONS ON BEHALF OF THE PRINCIPAL?

There is generally a range of factors that inform the agent on how to make decisions that can be analyzed after the fact if someone questions the decisions made by an agent. Each state has specific rules as to the fiduciary duties an agent named in a voluntary DPOA for property will be held to meet. The following discussion is a summary of the most common rules.

The starting point is whether the principal and agent have a specific conversation about a specific property decision (for example, with relevance to the principal being a participant in a qualified retirement plan, perhaps a specific discussion about naming a trust as a beneficiary for purposes of the required minimum distributions, or a specific discussion about how the 401(k) account balance should be invested while it remains in the corpus of the plan). If they have had such a specific discussion, then the agent *must* act in accordance with the principal's wishes and expectations. (Please hold your thoughts for a second if you are now thinking about what might look to the outside world like bad decisions.) If, however, the exact wishes and expectations are not known by the agent, but general philosophies are known, then the agent *should* offer his or her *best guess* at substituted judgment, and make decisions that he or she thinks the principal would have made (which again, might not look to outsiders as being in the best interests of the principal). Finally, if the agent has no idea what the principal would have wanted, and therefore cannot make decisions based on information actually known or through substituted judgment, then the agent *must* make decisions in what outsiders will objectively determine to be the *principal's best interests* (not the agent's best interests or in any other person's best interests).

How does an agent go about proving to third parties details about actual conversations he or she might have had with the principal? For example, consider the 401(k) plan investment decision. The plan participant is still alive, and for purposes of this example, assume he or she is still employed and is not considered disabled. An agent presents a DPOA over property, along with the relevant written opinions that match the wording in the effective event section of the contract. So you, as plan administrator, feel confident that the plan participant cannot make decisions over property and that this individual across from you properly has authority to make legally enforceable decisions on behalf of the participant. The agent now tells you that he or she wants to put 100 percent of the 401(k) account balance in the risky international fund. You are shocked, because based on modern portfolio theory and other past acts of this particular participant, this decision does not appear to be in the best interests of the plan participant. However, the agent says "A few weeks ago, when the principal had full capacity, we were driving in a car, and the principal expressly told me that his desire is to move all of his 401(k) money into the international fund." Or, he can say, "A few weeks ago, when the principal had full capacity, we were driving in a car, and the principal said that if Congress shuts the government and heads toward default, I think I might move all investments to international funds and stocks." Under most of the state laws on the fiduciary duty the agent owes to the principal, the agent is properly following the exact wishes of the principal, or is properly using substituted judgment. However, you, being the plan administrator and disinterested third party, are hesitant to acquiesce with this investment choice. Would you be so skeptical if the participant currently held 100 percent of his 401(k) plan account balance in the risky international fund and now an agent indicates that, based on actual conversations, the principal's account balance should be wholly invested in a target date fund appropriate for the principal's expected retirement age?

The purpose of this article is absolutely not to provide any legal advice to any plan administrator in any situation. This essay is more about thinking of potential situations before they actually happen. The plan's legal counsel should assist in any such decisions. Additionally, what I hope this essay is doing is alerting you, should you enter into a voluntary DPOA for property as a principal, in thinking about any actual wishes or general philosophies you have that might not look to the outside world as being in your best interests (even if they are). Do you ask the attorney drafting the DPOA to attach an affidavit that these are actually your wishes or philosophies?

Whether it is a plan administrator or the sibling living in California who is not the agent, the local court system of the state in which the

DPOA form is drafted should be able to settle any disputes of alleged impropriety (or breach of fiduciary duty) in the agent's decisions and actions, or indecisions and inactions. Generally, a DPOA for property is a voluntary contract entered into between the principal and agent. In many states, the interested third party can only bring a breach of contract case against the agent (pursuant to all local court rules regarding which parties can file the suit, what must be proven, what evidence can be introduced, and what remedy is available). However, in some states, such as Illinois, the DPOA statutes have been amended to include a specific cause of action for an agent's fiduciary breach of a DPOA contract (think of a federal cause of action in an ERISA plan for breach of fiduciary duty, but here, it is a state cause of action for an agent's breach of fiduciary duty).

Court-Appointed Guardians or Conservators

Depending on the particular state's laws and the specific circumstances, the guardianship can be plenary, meaning the guardian must make all decisions for the incapacitated individual, or the guardianship can be limited, meaning he or she is supposed to support the incapacitated individual generally, and is only authorized to make the specific decisions for the individual that are detailed in the court order. Remember, most states differentiate between a guardian of the property and a guardian of the person, so the court order should be clear, but some will be more complicated for third parties to read than others. Although many advocate for more instances of limited guardianship, primarily for the preservation of independence and dignity of wards of the state, these limited guardianships are replete with problems. Courts are generally backlogged and cannot amend court orders granting limited guardianship as the ward's mental capacity diminishes, and the guardian therefore should be making more and more of the ward's decisions.

If there is no DPOA for property (or if the agent named cannot act as agent, or if the event described as vesting authority in the agent has not happened), then all states provide for adult guardianship hearings. Usually, the judges who handle probate cases in any local court are the same judges who adjudicate adult guardianship cases. In most states, any "interested party" or "reputable person" can file a petition to classify an individual as lacking the mental capacity to make decisions, and, in most states, the decisions are divided between property or health. The key here is that unlike a voluntary DPOA contract, executed at the principal's convenience in an attorney's office, adult guardianship is an actual court hearing, replete with several attorneys zealously advocating for all the various parties, and of course their attorney fees, delays, evidence, testimony, judges, time, energy, emotional drain, and so on.

In all states, a "plaintiff" sues the "defendant," alleging that the defendant can no longer make decisions over his or her property, health, or both, and must produce evidence (most states required at least a written statement signed by a licensed physician). The "defendant" can produce alternative evidence (such as his or her own testimony, written statements from other licensed physicians, or statements by other professionals, such as licensed social workers or occupational therapists). The judge might appoint a *guardian ad litem*, to be the "eyes and ears" of the judge and physically visit the defendant (since the judge generally does not go to a residence or a nursing home). The judge determines mental capacity.

The guardian has a fiduciary duty to report back to the judge. A guardian over property (called a "conservator" in some states) must: prepare and follow an annual budget; agree to only spend the defendant's money on the defendant's needs and interests; report back to the judge at least annually; and, ask the judge before any unbudgeted amounts are expended or before disposing of or selling any property.

Since a guardian is named as a matter of law, plan administrators have no choice and must communicate with the guardian, assuming the guardian produces the court order. Similar to a DPOA for property, there might be general transactions or there might be limitations. It is up to the plan administrator to make certain that decisions over the plan benefits fit squarely within the court order. Again, if there is any doubt, then the plan's legal counsel should be contacted for an opinion.

RULES OF PROFESSIONAL RESPONSIBILITY REGARDING CLIENTS WITH DIMINISHED CAPACITY

Every attorney is bound to comply at all times with the rules of professional responsibility promulgated by his or her admitting jurisdiction (that is, the state in which he or she is admitted to practice). While free to develop and adopt their own rules for professional responsibility for admitted members of the bar, states often look to various sources for guidance. The most common source a state can use as a starting point is the American Bar Association's *Model Rules of Professional Conduct of 1983* (hereafter Model Rules).[5]

Basically, once a client chooses an attorney, the attorney must meet all the rules of professional responsibility regarding attorney-client relationships, individually and in the aggregate. Under Model Rule 1.1, the attorney must be competent, and under Model Rule 1.3, the attorney must be diligent. Under Model Rule 1.4, the attorney must communicate with the client. As indicated above, first the client must communicate his or her wishes, desires, and goals to the attorney; the attorney must communicate all possible legal alternatives to the client; and then the client must communicate the course of action

he or she desires. This is one of the most important underpinnings of a normal attorney–client relationship. Another crucial aspect of an attorney–client relationship is Model Rule 1.6, the confidentiality of a client's information. Under this extremely important rule, the attorney can only discuss a client's personal information if the client consents to the disclosure. To round out some of the more important rules, the attorney is required, under Model Rules 1.7 and 1.8, to avoid conflicts of interest, regardless of whether someone other than the client pays the attorney fees.

Model Rule 1.14, representing a client with diminished capacity, is the rule most relevant to this article. Even when the client has diminished capacity, the attorney is first required to attempt to maintain a normal attorney–client relationship (meaning that the attorney must find alternate ways of communication). Under Model Rule 1.14, however, if the attorney believes the client has diminished capacity, and the attorney believes that the client will be harmed unless the attorney does something, then the attorney may take actions that violate the other rules for maintaining a normal attorney–client relationship. The rule then reminds the attorney that this is the exception to the normal rules, and the attorney must do only as much as is necessary. Some of the measures an attorney can take include talking to other people to find out about the client and what actions might be in his or her best interests. However, talking to someone about the client's diminished capacity might, in and of itself, be harmful to the client. The attorney must balance the potential to protect the client with the potential to harm the client.

Therefore, in reality, there is a two-step process every attorney must follow every time there is a meeting with a client. First, the attorney must assess the individual's mental capacity in regard to whether the attorney can maintain a normal attorney–client relationship for an ongoing client relationship, or to establish a new attorney–client relationship if he or she meets the potential client for the first time. The attorney is basically assessing communication: can this individual communicate goals and desires; understand the choices that the attorney provides; and after understanding the consequences of any particular choice, communicate the choice back to the attorney. However, the assessment does not stop there, and the attorney has to now assess the individual's mental capacity in regard to whether he or she can legally enter into that transaction. Without going into the full details here, there is a certain level of capacity needed to enter into a simple will in which all children share equally, a higher level of capacity needed to specifically cut a child out of the will, and a still higher level of capacity if all assets are going to the caretaker who is 40 years younger and only known for the last three weeks. There is a certain level of capacity needed to ask for a divorce, a higher level

of capacity needed to marry someone who has been a friend and companion for 12 years, and a still higher level of capacity needed to marry the caretaker who is 40 years younger and only known for the last three weeks. Extending this logic to hypotheticals relevant to this article, for plan participants, there is arguably a certain level of capacity needed to elect to defer a portion of salary into a 401(k) plan and arguably a higher level of capacity needed to convert the traditional 401(k) account into a Roth account (if that is allowed). For business owners, there is arguably a certain level of capacity needed to terminate the plan, and arguably a higher level of capacity needed to convert a traditional defined benefit plan into a cash balance plan (or, using the preferred statutory language, an "Applicable Defined Benefit Plan").[6]

The final thought is that part of the legal analysis of mental capacity includes the concept of undue influence. Even when an individual ostensibly understands what is going on, if he or she is unduly influenced to make a decision or to enter into a transaction that is not in the person's best interest because he or she is coerced into doing so, the transaction might not be legally binding. Part of the comments to the actual rule suggest that attorneys are supposed to look for signs of undue influence at the same time they assess the total mental capacity.

CONCLUSION: A PLEA TO ALL PROFESSIONAL ORGANIZATIONS TO DEVELOP ETHICAL RULES REGARDING CLIENTS WITH DIMINISHED CAPACITY

As an attorney and an educator, I have noticed several things. First, that most people, on a personal level, do not understand issues with diminishing mental capacity, unless a friend, family member, or colleague suffers from a diagnosable disease, such as Alzheimer's or any other form of dementia, or just loses executive decision-making capacity as he or she ages. I am trying to educate as many people as possible to do advanced planning, such as having a properly executed DPOA for property and for health that accomplishes their specific goals as principal. This article might assist the plan administrators and consultants of the world to recognize when a plan participant does not have mental capacity sufficient to make a decision about the plan, and to efficiently deal with someone claiming to be the agent or guardian of that individual. In addition, the better educated about this you are, then the better you can educate your clients and their workforces (can you find ways to add profitability to your practice by educating clients and their workforces about aging issues associated with retirement finance issues?). Additionally, as individuals, I hope this article educates you and encourages you and your family to do proper planning.

Another interesting thing that I have noticed is that this rule of professional responsibility—how to deal with a client with diminished capacity—is enforceable in all states, meaning that attorneys can be disbarred or subject to malpractice liability if they do not comply with the rule (remember, ignorance of the law is no excuse). However, out of all the different types of attorneys there are only criminal attorneys (did the defendant have mental capacity at the time of the commission of the crime; does the defendant have capacity to sit in the trial; and so on), elder law and estate planning attorneys (does the older client have the capacity to enter into this transaction), and disability attorneys (especially if their client bases include people with mental illnesses) seem to even know about the rule. Even at my law school, my colleague who teaches professional responsibility admits that very little class time is devoted to this particular rule. So I am trying to educate as many attorneys as possible that this is a rule they need to learn about and incorporate into their normal business practices.

And since attorneys have a rule, but many are not aware of it, I find this a crucial time to ask all professional organizations to debate whether they need to incorporate a rule about clients with diminished capacity. Accountants do not seem to have a specific rule in their code of ethics but have a list of resources available.[7] There are various organizations for financial professionals, none of which seem to have specific rules.[8] Securities dealers regulated by FINRA have amended their suitability rule to account for clients with diminished capacity.[9]

In this conclusion, the author respectfully requests leaders of the various plan professional organizations,[10] which have among their members plan administrators and consultants, to review their ethical standards and see whether any prohibitions, warnings, or tools are needed regarding diminished capacity. Again, plan administrators and consultants might deal with plan participants with diminished capacity, but also might deal with business owners or other officers representing a business client who might have diminished capacity. Finally, as there is a lot of coordination of projects between and among colleagues, there should be a rule about the way a plan administrator or consultant should deal with (and report) a colleague's diminished capacity. Remember, in all cases, individuals who have full mental capacity are entitled to make bad, stupid, or otherwise questionable decisions, even if the decisions are harmful to themselves. But, once the individual loses the requisite mental capacity, then our society and laws demand that a surrogate make legally binding decisions on their behalf. Professionals (such as pension administrators and consultants) need to have ethical rules in place so that there is a positive and proactive path to take once they come in contact with an individual with diminished capacity, and with a such a rule, tools, best business practices, and a general competency will follow.

NOTES

1. Charles P. Sabatino, "Assessing Clients With Diminished Capacity," 22 *Bifocal* 1 (2001) (citations omitted). *Bifocal* is the newsletter of the American Bar Association Commission on Legal Problems of the Elderly. Although Sabatino's article is geared toward attorneys, it can be instructive for other professionals. The article continues: "The inclusion of a set of values and goals sets this definition apart from many other attempted articulations. Those values and goals establish a benchmark against which capacity can be assessed, for capacity must be judged according to a standard set by that person's own habitual or considered standards of behavior and values, rather than by conventional standards held by others. This is a principle more easily respected in theory than practice, but it is fundamental. Applying such a standard requires a more thorough knowledge of the individual than is normally feasible in a limited, one-time only encounter." (citations omitted).

2. There are three publications: Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists; Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers; and, Judicial Determination of Capacity of Older Adults: A Handbook for Judges; all available for download in PDF format at *www.apa.org/pi/aging/programs/assessment/*.

3. The advanced planning described in this article is limited to durable powers of attorney for property, which allow a principal to name an agent to ultimately make decisions over the principal's property. Other advanced planning, which relates to decisions over health, are not discussed in this article. Those documents include:

- A durable power of attorney for health, which allows a principal to name an agent to ultimately make decisions over the principal's health, including: should medical procedures be opted for; should artificial life-sustaining equipment be inserted or removed; should the individual be institutionalized (mental institution or nursing home); should there be an autopsy after death; or should any of the organs be donated after death;
- A living will, whose sole purpose is a notification to the attending physician that the individual does not want artificial life-sustaining equipment to be used to prolong life;
- A mental health declaration, whose sole purpose is a notification to the attending physician that the individual does or does not want certain treatments, including how much and how often the following are administered: psychotropic medications, electroconvulsive treatment, and admittance to and retention in a facility;
- A do not resuscitate (DNR) order, whose sole purpose is a notification to the attending physician and emergency medical personnel that the individual does not want cardiopulmonary resuscitation, intubation, or ventilation; and
- A physician order for life-sustaining treatment, whose sole purpose is to record the individual's wishes as the disease that will most likely cause death progresses.

The professionals most familiar with all types of advanced planning are elder law attorneys. Many local and state bar associations have an elder law committee, and the National Academy of Elder Law Attorneys organization assists people in finding an elder law attorney based on their state of residence.

4. *See, e.g.,* the Illinois Statutory Short Form Power of Attorney for Property (revised July 15, 2011), defined statutorily at 755 ILCS 45/3-3 and available at *http://gac.state.il.us/pdfs/poa_property_july2011.pdf*.

5. Available at *www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/model_rules_of_professional_conduct_table_of_contents.html*.

6. *See* IRC §411(a)(13)(C)(i), as added by the Pension Protection Act of 2006. For a more detailed (and whimsical) discussion of the confusion of what to call a plan that has colloquially been called a cash balance plan since the mid-1980s, *see* Kozak, "Employee Benefit Plans and Issues for Small Employers," *Bloomberg BNA Tax Management Portfolio TM-353-4th* (2010), at III.A.3.b.(2)(f).

7. *See, e.g.,* Sullivan, "CPAs in an Aging Society: When Alzheimer's Disease Affects a Client," *Journal of Accountancy* (2010), with a list of resources (*Adviser's Guide to Counseling Aging Clients and Their Families* (#091024); *CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide* (#022511); The CPA's Guide to Long-Term Care Planning (#017259); and, *A Guide to Financial Decisions: Implementing an End-of-Life Plan)*, available at *http://www.journalofaccountancy.com/NR/exeres/54C42D4D-90C3-4BC9-8728-8A9F79F3764C.htm*.

8. However, *see, e.g.,* "Financial Advisors Owe Special Duties to Clients With Diminished Mental Capacity," Page Perry LLC (2012), available at *http://www.pageperry.com/blog/financial_advisers_owe_special/*; and, "A Financial Professional's Guide to Working With Older Clients), AARP and the Financial Planning Association (2011), available at *www.aarp.org/content/dam/aarp/money/how_to_guides/2011-08/Financial%20Professional%20Guide%20Working%20Older.pdf*.

9. In Regulatory Notice 12-25 (2002), in providing additional guidance on FINRA's new suitability rule 2111, at Q&A-16, in response to "What constitutes 'reasonable diligence' in attempting to obtain the customer- specific information?" a clause is added "A broker may not be able to rely exclusively on a customer's responses in situations such as the following: … the customer exhibits clear signs of diminished capacity, …", available at *www.finra.org/web/groups/industry/@ip/@reg/@notice/documents/notices/p126431.pdf*.

10. In full and fair disclosure, the author is active in several professional associations, including the American Society of Pension Professionals and Actuaries, the Retirement Income Industry Association, and the Society of Financial Services Professionals.