ADVANTAGE COMPENDIUM

Addressing The Challenges Created By Cognitive Changes In Seniors

Special Report 2012

Changes in senior decision making...redefining who is a senior...the prevalence of dementia and cognitive impairment...elder abuse laws...what is suitability...how to address the problem

Conclusions

- Seniors do need to be treated differently. However, based on cognitive research, a cut-off point of age 80 rather than age 65 should be used to define who is elderly from a decision-making point of view
- If you take a strict look at the way suitability is defined by FINRA and NAIC regulations, having dementia does not necessarily affect the suitability of the sale. However, a person with dementia does not have the legal capacity to enter into a contract
- Due to the increased likelihood of dementia or cognitive impairment, financial professionals need to reexamine how they work with consumers in their eighties
- Even seniors with mild cognitive impairment may be able to make informed decisions if the financial professional has training in senior decision-making
- State elder abuse laws need to be changed to create a safe harbor against prosecution for financial professionals that provide financial products to seniors when the financial professionals are acting without criminal intent

Introduction

This is an analysis of issues relating to senior decision-making as it pertains to financial professionals. It was prompted by a case in California wherein a financial professional was convicted under elder abuse laws of grand theft from an elder because he sold an annuity to an 83 year old woman that the jury believed had Alzheimer's disease at time of the sale (Marrion, 2011). This report examines issues in senior decision-making, the prevalence of dementia and cognitive impairment in seniors, the concept of suitability, what constitutes elder abuse, alternative ways to address the challenges, and ways financial professionals and other parties can help seniors make better financial decisions.

We need to get a few definitions out of the way. *Cognition* or *cognitive* refers to the process of reasoning. It could also be called thinking, brain power or mental processes. This report uses all of these terms, but tends to use cognitive more because it is an accepted term in both medical and academic fields. *Dementia* is the deterioration of intellectual faculties, but in the medical and academic fields it tends to refer to a state where the mental faculties have already declined to the point where fully rational decisions cannot be made. When the term dementia is used it refers to someone that may have Alzheimer's or a different type of dementia. The report also uses the term *demented*. Although the term may not seem politically correct, it is simply the medical term to describe one that is suffering from dementia. A person with dementia is cognitively impaired, but a cognitively impaired person may not have dementia.

There is something else I feel I should clarify. This report is designed to be an objective and dispassionate view of senior decision making and cognitive impairment. As such, it may at times come across as cold and unfeeling on the repercussions of dementia. My mother suffered from dementia in her final years and it was horrible to watch a wise woman slip away. I assure the reader that my personal feelings in this area are not dispassionate.

Who Is A Senior? (cognitively speaking)

At what age someone becomes a "senior" is open to debate. AARP uses age 50 (although they seem to try very hard to never use the "s" word). Some academic studies have used age 50 or 55 as the start point. The U.S. Senate Committee on Aging and many state elder abuse laws use age 60, and state insurance regulations regarding special annuity suitability rules apply them beginning at age 65. I have said that a senior is someone at least twenty years older than you are. However, from a cognitive perspective I suggest that "senior" be applied to those over age 80.

Although mental processing ability (also called *fluid intelligence* or *working memory*) begins to drop in our late teens, this drop is more than offset by the knowledge being obtained (also called *crystallized intelligence*) (McArdle et al, 2002). The result being that our financial decision-making powers increase until we are around age 60 – although one study (Horn, 1986) says we hit the height of our wisdom around age 70. At some point the drop in mental processing ability offsets the knowledge advantage and our decision-making powers begin to decline, but the decline is usually very, very gradual – the decisions of a 75 year old are not any worse than that of a 35 year old because the knowledge advantage of the septuagenarian trumps the faster brain processing of the tricenarian, but the 55 to 60 year old version of both makes incrementally better decisions (Cattell, 1987). However, studies reveal that as we pass age 80 the number of individuals showing cognitive impairment increases markedly.

The Plassman study, discussed at length in a future section, found that while four out of five 70 year olds were not even mildly cognitively impaired, fewer than one in two had full cognitive abilities at age 80. Although full blown dementia affected only one in twenty 70 year olds the number of 80 year olds afflicted was roughly one in four.

At What Age Does One Become Elderly?

If you use history as a basis, both the British 1908 Pension Act and Germany's 1889 Pension Bill used age 70 as the cut-off to determine old age. The original *Senior Protection In Annuity Transactions Model Act* passed by NAIC in 2003, FINRA Notice to Members 07-43 and the more recent California Financial Elder Abuse & Senior Fraud Laws use age 65 as a cut-off point to determine who is a "senior" or an "elder", but this age is not only arbitrary but inaccurate from a cognitive point of view.

All of these "senior" consumer laws use age 60 or 65 as the point where someone becomes elderly or senior, but from a decision-making point of a view a 65 year old makes decisions as well as a 25 year old (Spaniol & Bayen, 2005). The vast majority of people in their 70s still can make good decisions (Plassman, 2008). Those that maintain that a 65 or 70 or 75 year old should not be treated any differently than younger people and do not need any special legal protection are generally correct from a decision-making point of view. However, this does not mean that all seniors should be treated the same because there is a point where age matters.

Brain Aging

Last fall columnist Robert Powell mentioned the results of a study that concluded that our financial decision making ability begins to decline as we get closer to the end of life (http://articles.marketwatch .com/2011-10-27/finance/30804275_1_financial-literacy-marketwatch-money-quiz). The study, which is mentioned in the improving decision-making section of this study, discovered that financial literacy decreases by 2% each year after age 60. The Powell column generated hundreds of very strong comments, mainly from readers over age 60, stating that the research must be wrong because they were not stupid. The reaction to the study highlights the extreme sensitivity that surrounds aging and cognition. It appears seniors will accept being told that they cannot run as fast, see as far or even make love as well as they did at age 25 – witness the ubiquity of reading glasses, canes & walkers, and Viagra commercials – but to suggest that their mental powers have declined often produces a very strong denial.

However, the reality of aging is we don't process information as quickly as we once did. The other reality is one out of six people aged 71-79 and one out of three people aged 80-89 have at least mild cognitive impairment. Impairment is not the same thing as dementia; impairment means that sound decisions may still be made, but it also means that the impairment needs to be considered when presenting the information on which to base the decision.

A demented person *cannot* make an informed decision. A person that is cognitively impaired *may* be able to make an informed decision if the information is presented in such a way that it works around the impairment. The mental processing abilities of a non-impaired senior may also be helped by recognizing that working memory declines with age and modifying how the information is presented.

Today's lifespan tables that attempt to conclude how long we may live are based on the *Gompertz Makeham Law of Mortality* discovered in the 19th century that found after we reached adulthood our age and mortality are log-linearly related (mortality is predictable with most deaths occurring as we near the end of human lifespan). Lifespan used to be considered a more or less set number, but our ability to replace decaying body parts – primarily clogged arteries – has added eight years on to the "maximum" lifespan in the last 50 years (Strulik & Vollmer, 2011). Science has shown that our physical lifespan can be increased and may continue to increase as medical advances continue, but it has also made us more aware that there is also a cognitive lifespan caused by a decaying brain.

A computer getting data through a DSL (digital subscriber line) that is then processed by a Pentium chip will reach the answer faster than one using a modem and an Intel 8086 processor. Both can solve problems, but the older processor can only take in only so much data at a time and then it processes the data more slowly than the computer with the Pentium chip. One should think of how your brain ages in a similar way. A computer processor is much like our working memory. During the decision-making process our minds are fed streams of data that we then need to temporarily store, while simultaneously being able to determine to what degree different parts of the data are useful to our decision, doing comparisons and rankings between the different types of data and also accessing stored knowledge to determine whether the data is consistent with what we know, coordinating it all to put it in a form that we can process, and then sifting and sorting through our past knowledge again to see if the new decision is similar or contradicts a past decision reached, so that finally a new decision can be made (Heinz-Martin et al, 2002). It is an extraordinary process.

Two related factors affecting senior decision-making are the slowing of reaction time in processing, comparing and coordinating all of these pieces, and a decrease in the total data we are able to hold in our heads. Seniors process decisions more slowly than young adults (Bopp & Verhaeghen, 2007). However, to continue the computer metaphor, as we age we store more and more data on our mental hard drive. A young person needs to wait for all the pertinent data to come through the DSL to make a good decision. An old person often already has this pertinent data stored in their memory so they do not need as much new data to arrive at the same good decision. Because of this "mental hard drive" seniors are able to continue to make good decisions well past age 65, even though they have less working memory. However, as we age a growing percentage of seniors begin having problems with their processors.

The Plassman Study

In 2007 and 2008 the results of large studies on cognitive impairment in seniors were published. The authors were over a dozen psychiatrists, psychologists, medical doctors and professors from the world of gerontology and senior decision making led by Dr. Brenda Plassman. The Plassman study found that although only 1 in 20 of those seniors in their 70s demonstrate dementia (Alzheimer's, senile dementia, other dementia) that figure increases to 1 in 4 for people in their 80s and over 1 in 3 after age 90. They also found that many seniors without dementia still experienced cognitive impairment in decision making.

Out of 20 people, those that will have *dementia* or *mild cognitive impairment*

In their 70s

In their 80s

In their 90s

For seniors in their 70s the study found 1 in 6 had some cognitive impairment, but that figure rose to 1 in 3 for seniors in their 80s and 2 in 5 for seniors in their 90s. When you combine the numbers you find that while only 1 in 5 seniors in their 70s have any cognitive impairment the odds dramatically increase to 1 in 2 for seniors in their 80s and 3 in 4 for those over age 90.

Some cognitive impairment does not mean that a good decision cannot be reached. It means that the impairment must be considered when presenting the data. However, the magnitude of the effects of these studies need to considered in selling to seniors.

	Percentages with Dementia (includes Alzheimer's, vascular dementia and other dementias)	*Cognitive Impairment without Dementia*
Ages 71-79	5.0%	16.0%
Ages 80-89	24.2%	29.2%
Ages 90+	37.4%	39.0%

The results strongly show that from a probability point of view the financial decisions of a random 65, 70 or 75 year old will be no worse than someone age 50, a point I stress under the *Elder Abuse* section. This is particularly true if the financial professional follows the guidelines found in the *Improving Senior Decision Making* section. However, probability also indicates that the financial decisions of a random 85 year old may well be worse than someone age 50. The study found that 1 in 4 seniors in their 80s had dementia and roughly 1 in 3 suffered some cognitive impairment, so, overall, 1 in 2 had problems.

From a business standpoint compare the septuagenarian market to the octogenarian one. If a financial professional has appointments with 20 random 70 year olds the odds are that 15 of them can understand what the financial professional is talking about as well as a much younger consumer, 4 of them may be made to understand if the financial professional takes into account the nature of the individual's cognitive impairment and copes with it, meaning only 1 consumer is a no-sale. If a financial professional has appointments with 20 random people in their 80s the odds are that 9 of them can understand what the financial professional is talking about as well as a much younger consumer, 6 of them can probably be made to understand if the financial professional takes into account the nature of the cognitive impairment and manages to cope with it, meaning 5 consumers are a no-sale.

Validity of the Plassman Study

Although there have been previous studies examining the extent of dementia in seniors the Plassman *et al* study is the most comprehensive.

If it is true that 24% of people age 80 or older have dementia (Alzheimer's disease, vascular dementia and other dementias) this should cause a reexamination of how society relates to the elderly on all levels. First we need to know if the research that produced this figure is well supported. My answer is it is.

The study sample contained 856 people that were aged 71 or older. Each age group (71-79, 80-89, 90+) was adequately represented in the study. This sample was derived from a much larger sample from the nationally representative HRS. The University of Michigan Health and Retirement Study (HRS) is a longitudinal panel study that has surveyed a representative sample of more than 22,000 Americans over the age of 50 every two years since 1992. The sample is sufficiently large and diverse that it is extremely unlikely that any type of sample bias, including selection bias, affected the results.

The participants were tested for dementia by a nurse and neuropsychology technician that administered a neuropsychological battery of tests that included measures of orientation, verbal and visual immediate and delayed memory, language, attention, executive function, praxis, reading ability and general intellect. All of this data was then reviewed in case conferences attended by a a geropsychiatrist, neurologist, neuropsychologist, a cognitive neuroscientist, and the nurses and neuropsychology technicians. The tests have a proven track record of being able to identify dementia and the people examining the results of the tests have years of experience in the field.

I believe the methods used show strong internal and external validity. The tests show high construct validity and measure what they are trying to measure. Yes, the results should be considered valid.

It should be noted there is a strong element of self-selection that reduces the odds of working with an impaired individual. An impaired person may be less likely to seek the services

of a financial professional meaning that in actual practice the probability of encountering an impaired client is significantly less than that portrayed in the study. To wit, although 1 in 5 septuagenarians in the population are impaired there would be markedly fewer actively working with a financial professional. However, even though this reduction would also hold true for 80 year old clients there would still a large number that were impaired. Thus, a cut-off point of age 80 rather than age 65 would more accurately reflect those more likely to demonstrate the limitations caused by age and thus be defined as elderly.

Mild Cognitive Impairment

A person with mild cognitive impairment often appears normal. They are able to express their feelings, talk about their concerns and state their preferences (Feinberg & Whitlatch, 2008). What this suggests is a senior with mild impairment may well be able to discuss and understand different investment and financial strategies at a global level (Okonkwo, 2008). For example, a mildly impaired individual may have the capacity to say they prefer an income they cannot outlive; or that they understand the relative risks of stocks and bonds and prefer a diversified portfolio of equities over one of bonds. However, they may not have the capacity to understand the financial impact of these decisions.

A 2010 study found that persons with mild cognitive impairment perform poorly in financial tasks such as understanding their bank statement, paying bills, and in understanding financial math. Even when they experienced actual losses they tended to ignore these real experiences in making new decisions. The IGT (Iowa Gambling Task) is a test that measures decision-making using stacked decks of cards, with some decks providing a better chance of winning than others. A non-impaired person will place smarter bets over time as they see how the pervious bets have panned out and move to the stacked decks that allow them to win. An impaired person continues to make bad bets and will randomly move between decks. The study found mildly impaired people did not use the results of the past to make better decisions (Zamarian, 2010).

The financial implications are profound. Even when a mildly cognitive impaired person has experienced actual losses from making bad decisions they will ignore these results and continue to make the same bad decisions. If told they are making bad choices they will randomly make new choices without taking into account past experience thus making similarly bad choices repeatedly. To put this in perspective, it does not matter if an impaired person is shown charts and printouts of past or hypothetical performance, because they cannot adequately process this information in making a decision. A mildly impaired person may have the capacity to understand and demonstrate their preference between financial concepts, but they will be unable to grasp what the return numbers or quantifiable risk of loss means to them in financial terms or relate how those hard dollars choices will affect their future.

Dementia

Dementia is an acquired persistent compromise in intellectual function with impairments in at least 3 of the following spheres of mental activity: language, memory, visuospatial skills, personality, and cognition (Cummings, 1984). By that definition it includes those afflicted by Alzheimer's disease, senile dementia, and vascular dementia. A person with dementia is generally not considered to have the legal capacity to enter into a contract.

Mild cognitive impairment is a syndrome defined as cognitive decline greater than expected for an individual's age and education level, but that does not interfere notably with activities of daily life (Gauthier, 2006). A person with mild cognitive impairment does have the legal capacity to enter into a contract if it can be determined that the impairment still allowed the person to give informed consent.

A financial purchase from a person with dementia creates a voidable contract; a financial purchase from a person with mild cognitive impairment may or may not create a voidable contract. There are tests that help determine whether impairment is present.

Testing For Dementia

There are a variety of ways to test for dementia. The Alzheimer's Association makes available a list of the *Ten Warning Signs Of Alzheimer's* (the warnings would help to detect any type of dementia). The problem is unless the person's dementia is advanced it can be impossible to tell whether the person might simply be having a "senior moment" (e.g, isolated forgetfulness) during the course of the appointment. There are a variety of exams designed to test specifically for dementia. Popular ones are:

The Blessed Orientation-Memory-Concentration (BOMC) Test

Introduced in 1983 this test uses 6 items from the 29 item BIMC mentioned below that had the strongest predictive power. This short oral quiz is often given by non-medically trained people. It asks questions testing understanding of time, mental processing and a simple memory test. The answers are weighted and the results are easily scored. If the score is below the cutoff point dementia or cognitive impairment is not apparent. If the score is above the cutoff then further testing is indicated. This often published test is copyrighted by American Psychiatric Association. A copy of the test is at the end of the report.

The Blessed Information-Memory-Concentration (BIMC) Test

Created in 1968 this 29 item exercise tests the memory with questions such as "where were you born" and "who is the current president." A couple of the questions, asking what were the dates of the first and second world wars, may need to be replaced, but overall the test has held up well. The test is usually given by those medically trained. This test is copyrighted by American Psychiatric Association.

Folstein Mini-Mental State Examination (MMSE)

Typically given by clinicians, this test uses standardized and interpretive items. The tester will name three unrelated items and then ask them to be repeated later in the exam. The participant will be asked to write a complete sentence – an independent subject and verb expressing a complete thought. The participant will be asked to copy a design. This test is patented by Psychological Assessment Resources.

Montreal Cognitive Assessment, (MoCA)

Introduced in 1996, this more directly tests mental processing powers by asking participants to identify pictures of a lion, rhinoceros and camel and deals in mental abstractions as well as memory testing. This test is typically given by clinicians and is copyrighted Dr Z. Nasreddine.

All of these tests have strong convergent validity (meaning that a persons's results are similar from test to test) in determining whether dementia is present. The Blessed tests (BIMC and BOMC) seem to also detect mild cognitive impairment. Questions have been raised as to whether MMSE does a good job of detecting mild cognitive impairment (Hoops, 2009).

The use of any one of these tests can detect dementia, meaning that the participant cannot make an informed decision. Some of the tests may detect evidence of cognitive impairment, meaning that the participant may or may not be able to make an informed decision. Financial professionals can easily be trained to give and score the BOMC test, and training people without a medical background to administer and score MoCa results should also be doable.

Financial professionals and staff of broker/dealers, advisory firms or insurance companies can test clients for cognitive impairment and identify those suspected of having dementia with a high degree of accuracy. The question is should they?

Senior Regulations

In September 2003 the ***Senior Protection In Annuity Transactions Model Regulation*** was adopted by the National Association of Insurance Commissioners (NAIC). It set forth standards and procedures for recommendations to senior consumers that resulted in a transaction involving annuity products (Marrion, 2003). The current version of NAIC #275 titled ***Suitability in Annuity Transaction Model Regulation*** modifies this to say that regardless of age the annuity proposed must be suitable.

In September 2007 FINRA (née NASD) published ***Regulatory Notice 07-43 Senior Investors*** saying that a priority of the regulator was the protection of senior investors. The notice talks about "Diminished Capacity and Suspected Financial Abuse of Seniors" stating that this is a troubling issue, especially as it relates to possible financial abuse of seniors by their families or caregivers. FINRA suggests that firms provide written guidance on identifying mental impairment and signs of financial abuse by others. On 22 September 2008 the SEC released a study titled ***Protecting senior investors: Compliance, supervisory, and other practices used by financial services firms in serving senior investors.*** The study was designed to "to identify and publish examples of practices that financial services firms have developed with respect to their interactions with senior investors." An addendum followed on 12 August 2010.

Senior (Elder) Financial Abuse

Not every state has elder abuse laws, but every state has laws against exploiting adults that are impaired. Indeed, the laws of every state say you cannot abuse impaired adults and there are roughly 20 that also have specific elder abuse laws designed to protect adults age 60 or older (65 or older in a handful of states). Only a fifth of the states make financial exploitation of the impaired or elderly a criminal office, in the majority of the states it is a civil matter. The National Committee for the Prevention of Elder Abuse (NCPEA) says that financial abuse includes:

- Taking money or property
- Forging an older person's signature
- Getting an older person to sign a deed, will, or power of attorney through deception, coercion, or undue influence
- Using the older person's property or possessions without permission
- Promising lifelong care in exchange for money or property and not following thru
- Confidence crimes ("cons")
- Scams are fraudulent or deceptive acts
- Fraud
- Telemarketing scams.

According to 164 deputy district attorneys, senior law enforcement detectives, adult protective service workers, and public guardians and victims for elder abuse to occur:

1. There must be an emotionally or mentally vulnerable senior with assets
2. Either the financial transactions or the senior are kept secret or controlled
3. No independent determination was made that the senior could act in their own best interest
4. The benefit received was not proportionate to the assets transferred
5. The transactions are not in writing, are poorly disclosed and represent a conflict of interest

If all of these are in place then there is elder abuse (Kemp, 2005).

The Kemp research says that all five of the circumstances must be in place for elder financial abuse to occur. The first four are judgment calls, but part of the fifth requirement, that the transaction was not in writing, is never true for any annuity because all annuity transactions are in writing, and may or may not be true for purchases of other financial products. Based on a strict interpretation of these guidelines the sale of any annuity could never be considered elder abuse. However, state laws may have different standards.

California Penal Code Section 368

(d) Any person who is not a caretaker who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of an elder or a dependent adult, and who knows or reasonably should know that the victim is an elder or a dependent adult, is punishable as follows:

(1) By a fine not exceeding two thousand five hundred dollars ($2,500), or by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, or by a fine not exceeding ten thousand dollars ($10,000), or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding nine hundred fifty dollars ($950).

(2) By a fine not exceeding one thousand dollars ($1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding nine hundred fifty dollars ($950).

The California penal code says that fraud or theft are crimes against elders. California penal code section 487 says grand theft involves the illegal taking of property worth more than $950. To be convicted of grand theft there must be intent to steal; one way to show this would be if you knowingly and intentionally deceived another by making false or fraudulent representations (http://www.shouselaw.com/grand-theft.html).

California requires that financial institutions must report suspected elder financial abuse. The fine for not doing so is up to $1000 and it appears the financial institution can be fined even if there was no reason for suspicion (California Welfare and Institutions Code 15630).

One problem with the California code sections is what constitutes fraud or theft is not well defined. It is apparent that elder abuse laws are designed to stop someone from stealing money from a senior's bank account or stop the huckster selling ownership in a nonexistent diamond mine, but what about the FINRA registered representative that sells U.S. Treasury notes to a senior and then interest rates rise so the notes are worth less. Is the representative guilty of theft by misrepresentation because the rep didn't ensure the senior fully understood that rising rates were a possibility? Or what about an annuity agent selling a fixed annuity to a senior that may have dementia, but no signs are present. Is the agent guilty of grand theft by larceny because the surrender charges temporarily deprive the senior of a major portion the property's value? [People v. MacArthur, (App. 4 Dist. 2006) 142 Cal.App.4th 275]

Another problem is the California law says that everyone 65 years or older should be treated the same as those younger adults confined to long-term care facilities or with diminished mental abilities (California Welfare And Institution Code Section 15610.233112 definition of a dependent adult). In addition to being insulting, the reality is the typical 65 year old makes as good or better decisions than the average 25 year old and does not need the protection.

Two problems with elder abuse laws, such as the one in California, is they tend to treat all those over age 60 or 65 as having diminished cognitive abilities and they may treat all those that work with seniors as predators, rather than realizing that laws already on the books protecting dependent adults under age 60 or 65 automatically protect those over age 65. Perhaps, most importantly, current laws and regulations completely ignore the scientific findings that those age 65 or 70 or 75 are, for the overwhelming part, not cognitively "senior" and makes decisions as well as everyone else. This is not to say that elder financial abuse does not occur. That there is elder financial abuse is readily apparent.

The Prevalence of Abuse

Elder abuse can be physical, sexual, emotional, or neglect. Financial abuse in the form of exploitation is another category of abuse. Based on the numbers out there no one can determine how big a problem elder financial abuse is. Indeed, the National Center on Elder Abuse (NCEA) states that they simply do not know the size of the problem. That it occurs, affects many seniors and results in much money stolen is without question. The problem is there is a degree of hyperbole and outright guessing that surrounds the issue.

A 1986 study estimated that between 701,000 and 1,092,560 elders were abused and some of this involved financial abuse (Pillemer & Finkelhor). Studies in the early '90s concluded at one point that 293,000 elders were abused each year (Tamara, various). The U.S. Administration on Aging site (http://www.aoa.gov) has a link to a 1998 NCEA report. That study concluded that 450,000 elderly persons in domestic settings were abused and/or neglected. They based this number on 70,492 actual reported and substantiated elder abuse cases in the nation in 1996. However, they then announced that by using the *iceberg theory of elder abuse* that there were approximately 378,982 unreported cases of abuse for a total of 450,000. Giving this number credence, based on the then senior population that would translate into an overall elder abuse rate of 0.7% to 1.2% in 1996.

A study (Jogerst) produced in 2003 using actual abuse report totals from 47 states found that allegation of all forms of elder abuse represented 0.86% of the population over age 60 (by my estimate 300,000 seniors across the country). However, after these allegations were investigated the percentage of confirmed cases of abuse was 0.27% of the senior population (roughly 94,000 cases of substantiated abuse).

A study produced by Illinois (Illinois Department on Aging Elder Abuse and Neglect Program, FY 2007) said out of a state population of 1.9 million seniors there were 9,489 elder abuse reports filed of which 54% were substantiated; of the total complaints 5,599 alleged financial abuse. In 2007 there were 37.9 million seniors in the nation and Illinois had 1/20 of this total. If you multiple the number of Illinois abuse reports (9,489) times 20 – making the assumption that Illinois is representative of the nation – the result is 189,780 reported cases or 111,980 estimated national cases of elder financial abuse, but substantiated cases would be 102,281 for all types of abuse and 60,469 for financial abuse.

An oft-cited number is there are 5 million annual cases of elder financial abuse. However, this is based on a Consumer Digest article where the reporter misread the study's results table. Based on the study he referenced there were, at most, 137,000 cases.

A conclusion in an article written by a reporter and published in *Consumer Digest* back in 2000 is widely repeated and says that they found evidence of 200,000 substantiated cases of financial elder abuse only, but they feel the real number is 5 million seniors suffer elder financial abuse. Wasik appears to have misread the NCEA study to reach his conclusion. This above mentioned study found 70,492 substantiated cases of actual elder abuse that included 21,427 cases of financial abuse. The original NCEA study then used a guessestimate based on a much smaller study to say there might be 450,000 reported and unreported cases, but their guess could be off by a couple hundred thousand. Wasik appears to have misinterpreted the NCEA study in a variety of ways. First he says there are 551,000 instead of 450,000 instances – however the higher number includes instances of self-neglect where no other party was involved. He then says these are 551,000 reported and substantiated cases of elder abuse and then postulates that 220,400 involved elder financial abuse. However, 80% of the instances included in the higher number are neither reported or substantiated, but are merely guesses.

Assuming his mistaken number is actual cases he still does not use the NCEA reported/unreported ratio of 6 unreported cases to 1 reported, but instead suggests that it should be a 14 to 1 ratio, and then revises it upward to 25 to 1 – with absolutely no basis in reality or sources cited (he even says it might be 100 to 1 which would mean two-thirds of all seniors are being financially exploited each year).

The 5 million financially abused elders figure apparently resulted by the inability to correctly read a table (even if the 25 to 1 multiplier he uses was not unsourced, based on actual elder abuse complaints the number of financial abuse instances would be 700,000 cases, not 5 million, and based on the NEA number the actual number of financially abused elders may have been somewhere between 80,000 and 137,000). The reporter admits that his speculations are not supported by the facts, saying that he contacted every state in the union and turned up "low numbers of abuse" but he then implies his own research is meaningless saying real numbers do not matter because "most of these crimes are never reported".

Every elder advocacy organization (and elder abuse lawyer) web site that I clicked on showed the 5 million cases quote, including the NCEA one that did the original study. I sent an email to NCEA explaining the error in the Consumer Digest article they were quoting from and they promised to not cite the article in the future, but it is still printed in their Fact Sheet.

Depending on whose numbers one uses there are anywhere from 300,000 to 900,000 annual cases of actual reported and unreported elder financial abuse, and the strongest studies conclude that 96% of this abuse results from family members and caregivers.

Financial professionals should be aware

The reality is out of roughly 40.4 million seniors (Administration of Aging, A Profile of Older Americans: 2011) probably 0.5% to 1.5% are financially abused each year. The odds are strong that a financial professional will never work with a senior that is financially abused. Another reality is maybe there are a few thousand cases a year where financial professionals exploit seniors – this would mean that, maybe, 0.005% of seniors are abused by financial professionals; statistically there is not a problem of financial professionals abusing seniors.

However, it is hard to get funding or new legislation passed if there appears to be few victims, so some try to create the idea that there are more victims and abusers than there really are. In addition, because it is so rare, the media and others tend to highlight instances where a financial professional has exploited a senior, which makes it seem more common than it is. My concern here is that the actions of a few financial professionals will be used as fuel to create legislation or regulator actions that make life more difficult for all financial professionals.

What can a financial professional do? Be aware that elder financial abuse exists and report it when you suspect it is occurring. Also be aware that half to three-quarters of financial abuse claims are not substantiated due to the fact that many are brought because someone did not get the money they thought they should have. Also be aware of what constitutes abuse in your state.

State Elder Abuse Laws

What constitutes elder abuse and the punishment if convicted varies widely. In California and Nevada a conviction of elder financial abuse can result in a prison term. However, in the vast majority of states it is a civil matter.

In Missouri [Code 570.145] financial elder abuse is narrowly defined as the permanent taking of property. Furthermore, the Missouri law states that elder abuse laws do not apply to "a person who has made a good faith effort to assist the elderly...in the management of his or her property." From reading the law it seems that acting in good faith as a financial professional would never be considered elder abuse in Missouri. Of course, I am not a lawyer and this does not constitute legal advice.

I am hopeful that further research will produced greater consistency in determining the number of seniors that are financially abused. Dementia and cognitive impairment increase as age increases. However, does it matter if the consumer has dementia if the sale is otherwise suitable?

Suitability Regulations & Dementia

If the buyer has dementia does that automatically mean the sale is unsuitable?

Persons with dementia have diminished capacity which prohibits them from making an informed decision. Taking this further, if a person in unable to make an informed decision he or she would be unable to determine whether a purchase is suitable for their situation. If the buyer is unable to determine whether a purchase is suitable, does that mean the sale is automatically unsuitable?

What do regulations say about suitability & the cognitive abilities of the buyer?

On 9 July 2012 ***FINRA Rule 2111 Suitability*** replaces NASD Rule 2310.

Section 2111.04 requires that a firm or associated person "have a reasonable basis to believe that a recommended transaction or investment strategy involving a security or securities is suitable for the customer, based on the information obtained through the reasonable diligence of the member or associated person to ascertain the customer's investment profile." ***It says nothing about the mental status of the buyer.***

Section 2111.05 says there must be reasonable-basis suitability, customer-specific suitability and quantitative suitability. ***It says nothing about the mental status of the buyer.***

On 9 July 2012 ***FINRA Rule 2090 Know Your Customer*** becomes effective. it states that "Every member shall use reasonable diligence, in regard to the opening and maintenance of every account, to know (and retain) the essential facts concerning every customer and concerning the authority of each person acting on behalf of such customer. ***However, it does not say whether these essential facts include the mental status of the buyer.***

Although the ***NAIC Suitability in Annuity Transactions Model Regulation 275*** conspicuously does not define the words "suitable" or "suitability" (Section 5. Definitions), it indirectly defines suitability as "recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately addressed" (Section 1.A). The model regulation does define "suitability information" appropriate to determine the suitability of a recommendation to include the annuity buyer's *age; annual income; financial situation and needs, including the financial resources used for the funding of the annuity; financial experience; financial objectives; intended use of the annuity, financial time horizon; existing assets, including investment and life insurance holdings; liquidity needs; liquid net worth; risk tolerance; and tax status* (Section 5. I. 1-12). ***It says nothing about the mental status of the buyer.***

Section 6.A. says the insurance producer, or the insurer where no producer is involved, "shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe...(1) the consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisor fees, potential charges for and features of riders, limitations on interest returns, insurance and investment and market risk; (2) the consumer would benefit from certain features of the annuity, (3) the particular annuity, as a whole, is suitable; and (4) in the case of an exchange or replacement of an annuity, the exchange or replacement is suitable.

Section C says an insurer shall not issue an annuity "unless there is a reasonable basis to believe the annuity is suitable based on the consumer's suitability information." Section F says the insurer must establish a system to supervise product training and establish procedures "to determine that a recommendation is suitable" (F.1.d). ***Sections 6 says nothing about the mental status of the buyer.***

Section 7 says the agent must be in compliance with the insurer's standards for training. The section mandates that agents complete a four credit training course and specifies the topics that must be covered. ***Neither these topics nor training standards address the issue of possible cognitive impairment of the buyer.***

It is probable that the reason that dementia is not addressed is because a person with severely diminished mental acuity does not have the legal capacity to make a contract, thus the sale is voidable so the suitability aspect is moot. In addition, the law presumes adults do have legal capacity until proven otherwise. These regulations may have been written with the belief that existing statutes already protect the demented. However, it could also mean the regulators realized that suitability and mental capacity are two entirely separate things.

A financial professional must gather *suitability information* to determine whether the purchase is suitable. With two exceptions, each of these decision factors are quantifiable and not subjective. The buyer's age, income, assets and tax status are all integers that could be obtained from the buyer's accountant. The buyer's financial situation, experience, liquidity needs and time horizon are also objective measures that can be calculated. The only reason the buyer even needs to be in the room is to tell of any special needs and to describe their tolerance for risk, but even here probabilities could be used to state what the buyer's needs and risk tolerance "should be" based on what others have done in a similar position. Due to the extremely strong reliance on using quantifiable facts to determine suitability it can be argued that the mental state of the buyer is irrelevant, with the understanding that a demented buyer is more likely to require intermediate nursing home care and this specific financial need must be addressed.

The gathering of suitability information under the NAIC model act already requires the financial professional to consider the other insurance needs of the annuity buyer. Assuming that either long term care insurance or assets are available to cover needs created by possible dementia, or that an caretaker is identified during the sales process that would fulfill the obligation created by dementia, then there is no reason – based solely on the information used to determine suitability – for the agent or carrier to make the cognitive state of the annuity buyer a variable in the suitability of the annuity buying decision.

Assuming the purchase meets the buyer's financial requirements, based on the suitability information collected, is it necessary for the financial professional to ascertain whether the buyer has the cognitive acuity to understand what was purchased and why? Neither securities nor annuities suitability regulations require the buyer to understand what they purchased only that they have been reasonably informed of the features and risks. Since annuity regulators have approved the sales material and disclosure forms, and the broker/dealer has approved usage of the securities materials by the financial professional, an argument can be made that a "reasonably informed" buyer is one that has received the approved sales materials and signed the approved disclosure form.

Returning to where this began, suitability is said to be making recommendations that appropriately address the needs and financial objectives of the consumer. The fact that the consumer may be demented is only a suitability concern as it relates to the cost of covering any insurance needs caused by the dementia, which is providing a caregiver. However, the need for a caregiver is not specific to dementia, and the need for a caregiver, in the form of a spouse or nursing home, should be a part of any suitability discussion regardless of whether or not the consumer has dementia.

What Does All Of This Mean For A Financial Professional?

The Plassman study found that 24% of the participants aged 80 to 89 had dementia; this is a fivefold increase from the percentage of 70-somethings with dementia. If you knew that there was a 1 in 4 chance of getting hit by a car when crossing a particular street would you continue

to cross that street? The first question the results of this study raises is ***should a financial professional accept <u>any</u> buyer age 80 or older***?

The risk of a demented buyer is considerably less under age 80; the probability of dementia for ages 71 to 79 was 5%. In the financial world a 95% confidence level in the accuracy of the results of a financial model is an acceptable bar for most decisions. A 5% dementia risk in 70 to 79 year olds means that 95% of any random group should not have dementia. Based on what are viewed as acceptable probability outcomes in other financial areas, it is reasonable that potential buyers in their 70s are as acceptable a market as younger buyers for financial professional, especially when one considers that self-selection furthers reduces the odds of facing a buyer with dementia.

The research says 1 in 4 study participants in their 80s had dementia, but that does not necessarily mean 1 in 4 octogenarian investors or annuity buyers do. There is an element of self-selection both for the buyer and the financial professional. The typical financial professional is not looking for buyers in the intermediate or skilled care sections of nursing homes; a person with dementia would be unlikely to seek out a financial professional for a financial purchase. Advanced dementia is easy to recognize and I would argue that a typical financial professional would not do business with an individual that appears to be severely demented. Therefore, although 1 in 4 octogenarian may have dementia the odds of the financial professional encountering and selling a financial product to an octogenarian with dementia are significantly less than 1 in 4.

The same self-selection would hold true for septuagenarians meaning that the actual odds of encountering a prospective buyer with dementia are really much lower than 1 in 20. This also supports my contention that prospects in their 70s should not be treated differently than younger buyers.

However, even though self-selection reduces the risk it still means potential clients in their 80s are much more likely to have dementia or other cognitive impairment and are significantly more at risk of not understanding the consequences of their decisions than younger buyers. A 24% risk is too generous a bar for most financial models and even though self-selection improves the odds it still strongly indicates that buyers in their 80s *should* be treated differently than younger buyers. There are different ways to deal with this risk. It should be noted that these are not recommendations, but simply a summary of all of the alternatives.

1. The financial professional refuses to sell to those over age 79.

Although I could not find demographic results for investors, my earlier research suggests the percentage of fixed annuity sales to those 80 and older is a very small percentage of total annuity sales. The financial professional should decide whether it is worth the risk to sell to this group.

2. All sales to those over age 79 voidable with or without limitations.

Every state requires the carrier to provide an annuitybuyer with a “free look” period wherein the buyer may return the annuity and get back the premium without penalty. A carrier could increase the period during which older annuitybuyers could return their policy to six months or indefinitely giving time for dementia to be observed.

This would be very difficult to do with investment products.

3. Someone with a power of attorney is required to act on behalf of those over age 79.

4. For those over age 79 the financial professional requires a notarized statement from a physician or mental health professional stating there is no evidence of dementia or cognitive impairment.

5. A cognitive test is required on those over age 79.

There are several tests for dementia described in this report, some can be conducted and scored by people without medical training. The financial professional would not do business if the test indicates dementia or impairment.

6. Continue to treat all buyers as a homogenous group.

Based on the study, 1 out of 2 octogenarian clients will not have dementia or other impairment and, in practice, the actual percentage of impaired clients should be much lower due to self-selection. If transactions with those over age 80 represent a small percentage of overall business, a much smaller percentage will have dementia, and an even smaller percentage of cases will result in requests to refund the transaction due to dementia. The broker/dealer, insurance company and financial professional could continue to treat everyone the same and deal with problems on a case by case basis.

What should be done?

There are ramifications in doing any of these alternatives. Simply setting a maximum age of 79 should essentially avoid the problem of selling to possibly demented buyers (statistically speaking), but it also means turning away from a market where the majority of the buyers do not have cognitive impairment. Treating all buyers over age 79 the same is the current practice, but this runs the risk that certain segments of this demographic may be more likely to be cognitively impaired and equal treatment may not be the best course of action. Making a contract voidable may lead to abuses, and is impractical in the securities world. Finally, a prospective client may not take kindly to being subjected to a mental test or needing a note from the doctor simply to make a financial transaction.

There isn't a one-size-fits-all answer. The two truths are those clients over age 79 need financial products and the services of financial professionals, and that a significant percentage of those over age 79 have dementia. Those that wish to work with this market will need to establish their own guidelines.

- An emergency or alternative contact should be in the senior's file.
- The benefits of a power of attorney should be mentioned while the senior is still in good health with the suggestion that an attorney be consulted.
- It becomes even more important with senior clients to keep extensive notes on any communications and to follow-up, in writing, what was discussed and agreed to.
- The financial professional, advisory firm, broker/dealer or insurance carrier should have procedures in places detailing what should be done when financial abuse or cognitive impairment is suspected.

What Has Been Done?

A 2008 study by the SEC revealed that some broker/dealers and investment advisory firms have implemented training to aid with communicating effectively with senior investors, training and educating employees on issues such as identifying signs of diminished capacity and elder

abuse, and determining which products are appropriate for seniors. The *NAIC Suitability in Annuity Transactions Model Regulation 275* requires annuity carriers to determine that annuity transactions are suitable at any age.

A Partial Response To Dementia – Asymmetric Paternalism

Asymmetric paternalism is a way of framing choices unevenly so that consumers will be encouraged to make better choices. An example would be a store where fruits and vegetables are in the front row at waist level and candy bars are in the back row at ankle level, or a fast food restaurant where the default beverage choice is flavored water instead of asking which sugary soda the customer wants (Loewenstein, 2007). The point is that better choices are encouraged, but not mandated. The consumer can still get the candy or the soda, but they have to make an extra effort. Asymmetric paternalism is the opposite of *mandated paternalism* – seat belts laws are an example of mandated paternalism.

It works. The most oft-cited example of it working was New Jersey passing a car insurance law where the default version put a cap on the damages you could collect in a lawsuit, but you could elect to pay more premium for an option with no cap on damages. At the same time Pennsylvania's default option remained no cap on damages, but you could get a hefty premium discount if you capped what you could sue for. In New Jersey 80% chose the default lower cost option, but in Pennsylvania only 25% chose the lower cost option (Johnson, Hershey & MesZaros, 1993). Those involved in the senior market may be able to use asymmetric paternalism if they decide to address the cognitive impairment issue.

If a broker/dealer or insurance company wishes to lower the percentage of people with dementia one way is to make selling to older ages, particularly those people over age 80, less attractive. Insurance companies already do this by creating asymmetric compensation where agents receive significantly less commission for those sales over certain ages. Another asymmetry would be to increase the commission chargeback period when the buyer is over age 79. The same things could be done on securities transaction with compensation lowered and/or held back for a period if the client is over age 79. Either of these actions work to discourage sales of those buyers most likely to suffer from dementia.

Another way to address the problem is to reward consumers that will test for dementia. As insurance laws are currently interpreted a carrier cannot base annuity interest rates or annuity benefits on whether a consumer agrees to submit to and pass a test to determine dementia. However, there are underwritten immediate annuities wherein consumers may receive a higher payout than from a non-underwritten one. Could there not be underwritten deferred annuities that would pay higher rates if the consumer tests and no dementia is shown? In addition, could broker/dealers offer reduced fees or additional services for those clients willing to take the test?

A third way would be to reward financial professionals that received training in identifying the warning signs of dementia and then demonstrated using that training in being more selective in picking clients.

Improving Senior Decision Making

A person with dementia cannot make an informed decision. A person with cognitive impairment may be able to make an informed decision (Feinberg & Whitlatch, 2001). The following will help anyone – not just the cognitively impaired – make better decisions.

Take Your Time

When seniors are given more time to study and remember new data they perform as well as young adults (Spaniol & Bayen, 2005). If seniors are not pressured and not rushed they tend to make decisions as well as anyone else.

Be Repetitious

Seniors may also have trouble learning new data, so it may take repeated exposure to get new data taught (O'Connor & Kaplan, 2003). This requires ongoing questioning to determine if the new data is being processed.

Take Breaks

A study had seniors and young adults make a series of decisions (Isella *et al*, 2008). The seniors did as well as the juniors in the early rounds, but the quality of the seniors' decisions faded dramatically after a certain point. The researchers believed this was due to a progressive loss of concentration.

The study found the mental stamina of the seniors ebbed over time – their brains got tired. A solution is to take breaks when you are meeting with seniors to allow them to refresh and restore their ability to concentrate.

Meet In The Morning

Seniors make their best decisions in the morning because that is when their mental faculties are sharpest (Yoon, 1997).

Connect Emotionally

There is a great degree of agreement that emotions affect decisions (Mata, 2007). In the case of seniors it has been found they respond better to, and remember more of, information when it is emotionally charged. Indeed, if the presentation mainly consists of spreadsheets, charts and other cold facts it causes decision-making to become more difficult (Hanoch, Wood & Rice, 2007). A better approach is to present factual information first and show through an emotional link how the senior's goal is reached

Give Enough Choices, But Not Too Many

In November 2005 Medicare made available what became a menu of 55 prescription drug plans. Of the 43 million eligible Medicare customers roughly 10 million – less than a quarter – actively decided to select one plan (Reed et al, 2008).What about the other three-quarters of eligible retirees? I believe they were crushed by choice overload wherein they were so afraid of making the wrong decision that they refused to make any decision.

When seniors were asked how many options they wanted to choose from the average senior wanted 4 choices when it came to picking a hospital or drug plan, 5 choices for a doctor or jar of jam, and 6 choices for an apartment or car (Reed et al, 2008). This does not mean the senior should be denied the availability of selecting from amongst the 8000 mutual funds or 600 annuities it means the financial professional needs to act as data-sorter to make the decision manageable.

No Insider-Speak

Every industry adopts its own shorthand. It's quicker to say MVA rather than market-value adjustment, or discuss relative investment product alphas and betas, but an outsider won't know

what any of those terms mean. Talk to the senior using words and concepts they can relate to, and this often means using basic financial terms.

Good Lighting & Good Contrasts

As we age our eyes have more difficulty seeing in low light and differentiating between subtle colors and shapes. This means using better illumination, higher contrasts and reduced glare (Yoon & Cole, 2008). What this means is use sharp contrasts on sales materials or on PowerPoint slides – not light blue contrasted with light green but dark green with medium blue; not violet but purple, not tan but brown. It also means using natural light or strong artificial light when presenting written material at an appointment Watch out for glare – a light pastel background on slides for a seminar is better than the glare produced by a white background.

No Background Noise

Aging means it is more difficult to detect low-intensity sounds and filter out background noise (ibid). This gives the edge to people that speak in the tones of sopranos and tenors and means the words of altos and basses don't get processed as well. This means if you have a deep voice you should try to speak in a slightly higher register. It also means a presentation will be better understood if it is conducted in a quiet room rather than a noisy restaurant, and the music in your office that you find soothing an older client may find distracting.

No Multitasking

Regardless of age, doing two or more tasks at the same time (multitasking) results in worse performance than doing each task separately, however, the consequences of multitasking are much worse for seniors. A recent study compared the results of young adults and seniors in managing to make it to the other side of an intersection crosswalk without getting hit by a car while being asked questions on their cell phone (e.g. read any good books lately, what are your favorite restaurants. etc). Young adults kept on walking while answering the questions and managed to avoid getting run over, but a high percentage of seniors either slowed down or stopped in the middle of the crosswalk to answer the questions and would have been road kill if the car hadn't been part of the study (Neider, 2011).

What this means is the presentation should be done in an atmosphere free of distractions (no TV or chatter in the background) and that concepts and benefits need to be presented one at a time so that you have the client's complete attention. If an interruption occurs, deal with it, and then return to talking about the financial product.

Financial Professional Actions That Help or Harm Senior Decision-Making

There are specific things a financial professional can do to overload working memory and cause worse decisions by seniors:

- Expand the disclosure to double digit pages by rehashing everything that is in the sales material and the contract or prospectus, instead of having the disclosure only contain those items that will have the greatest possible impact on the client and the greatest possible liability to the financial professional.

- Use multiple graphs and charts & offer complex products.

The items mentioned above may strain working memory resulting in less than optimal decisions by the buyer. However, there are certain things the broker/dealer, insurance company and financial professional can do to aid decision-making.

Larger Type – Select a font that is easily readable in a size that can be read.

Contrasts – As mentioned above, sales materials should use colors that provide contrast without glare.

Train – Financial professionals can be trained to work more effectively with seniors by helping them understand how the decision-making process is affected by aging.

The disclosure and presentation should focus on the key elements – My research indicates the three initial concerns of seniors are Safety: how can I lose and how much can I lose; Liquidity: how accessible is my money; and Returns: what is the worst and best I can do. Disclosure of these elements should be easy for the senior to read and understand.

Summary

The appearance of dementia, determined well after the time of the sale, was a factor that resulted in criminal action brought against a financial professional in the sale of an annuity that was approved by the state insurance department. The probability of dementia or other cognitive impairment increases dramatically after age 79. Although the vast majority of potential clients will not be demented, and even those with mild cognitive impairment can often make an informed decision, the risk of a sale to a demented buyer is much higher when that person is in their 80s. After the outcome of the Neasham case in California [Case CR 925185] all financial professionals need to reexamine how they will work with clients in their 80s. However, it should be noted that criminal prosecution for a transaction conducted in good faith by a financial professional with a senior is highly unlikely – even in California – and would be impossible in many other states.

Even without the threat of criminal prosecution, financial professionals need to recognize that seniors are different from juniors in their decision-making and need to change the way in which they interact. Financial professionals can be trained to work more effectively with seniors in a manner that maximizes the potential for the senior making a well informed decision and minimizes any Monday morning quarterbacking alleging that the sale was unsuitable; broker/dealers and insurance companies should make this training available to the financial professional. Financial professionals can also be taught how to conduct and evaluate cognitive test on seniors, but the question is whether they should.

State elder abuse laws were intended to protect seniors from those intending to abuse them; they were not designed to be used against those that act in good faith to help the senior. This is also an area where many complaints are falsely made; research indicates that 50% to 75% of elder abuse complaints cannot be substantiated and often are the result of confusion by the senior. All state elder abuse laws need to create a safe harbor against prosecution for those financial professional that work with seniors in good faith.

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The Blessed Orientation-Memory-Concentration (BOMC) Test

"Now I'd like to give you a short memory test that will take about 5 minutes. Some questions will be easy; some may be more difficult. Are you ready?"

Items		Maximum Error	Score		Weight
1.	What year is it now?	1		x 4 =	
2.	What month is it now?	1		x 3 =	
Memory Phrase	Repeat this phrase after me: John Brown, 42 Market Street, Chicago				
3.	About what time is it? (within 1 hour)	1		x 3 =	
4.	Count backwards 20 to 1	2		x 2 =	
5.	Say the months in reverse order	2		x 2 =	
6.	Repeat the memory phrase	5		x 2 =	

TOTAL
The scores from each of the six items are multiplied to yield a weighted score.

Score 1 for each incorrect response.

Scoring items 4 and 5: For uncorrected errors, score "2"; for self-corrected errors, score "1". For no errors, score "O"

Scoring the memory phrase: If no cue is necessary and the person recalls both name and address, score "O". If patient cannot spontaneously recall the name and address, cue with "John Brown" one time only. If this cue is necessary, the person automatically has 2 errors.

Score 1 point for each subsequent "unit" (street address, city) the participant cannot recall.

Weighted error scores greater than 10 are consistent with dementia.

Example:
If the person answers everything correctly then the score is zero. This is how you would score incorrect answers if it was 3:15 PM On 24 April 2012

Items			Maximum # of Errors		Factor	
1.	What year is it now?	*1964*	1	1	x 4 =	4
2.	What month is it now?	April	1	0	x 3 =	0
Memory Phrase	Repeat this phrase after me: John Brown, 42 Market Street, Chicago					
3.	About what time is it? (within 1 hour)	2:30	1	0	x 3 =	0
4.	Count backwards 20 to 1	missed 14, missed 6	2	2	x 2 =	4
5.	Say the months in reverse order	missed June	2	1	x 2 =	2
6.	Repeat the memory phrase	forgot Chicago	5	1	x 2 =	2
	Dementia is indicated			Total Score		12

A person is allowed 1 incorrect answer for the first three questions (even if multiple wrong answers are given the maximum score is 1).

On questions #4 & #5 a person is charged 2 points for each wrong answer, unless they catch their mistake, then they are only charged 1 point. The maximum points are 4 each (2 wrong answers) even if actual results are worse.

On the memory phase 1 point is assessed for missing each of the following: John, Brown, 42, Market Street, Chicago (since there are 5 things to remember the most possible errors are 5). If the person can't seem to get started, but can provide the complete address after being prompted with "John Brown" score 2 points.

A score of less than 10 is not conclusive proof that the person does not have dementia, but a score of 10 or greater is consistent with previous results indicating the presence of dementia. If dementia is indicated a physician should be consulted.

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Advantage Compendium Ltd. (www.advantagecompendium.com) is led by Jack Marrion, providing research and consulting services to financial firms in a variety of areas. He has conducted a broad scope of research ranging from the behavioral economic reasons why consumers buy or don't buy financial products to future industry impact models, as well as improving customer retention and discouraging outflow.

His insights on the annuity and retirement income world have appeared in hundreds of publications including *Best's Review*, *Business Week, Kiplinger, Smart Money, The New York Times*, and *The Wall Street Journal*. In 2009 Dr. Marrion was asked to speak at the National Association of Insurance Commissioners Washington meeting on how seniors make decision. *Best's Review* said he was likely to affect the course of the industry.

Prior to forming Advantage Compendium, Jack Marrion was president and owner of an NASD broker/dealer with offices in nine states, and formerly vice president of a life insurance company and previously vice president of an NYSE investment banking firm. Dr. Marrion has a BBA from the University of Iowa, an MBA from the University of Missouri and his doctorate from Webster University in the area of cognitive biases in decision-making formed a new paradigm in the marketing and development of retirement income products. Neither Jack Marrion nor Advantage Compendium sell or endorse any financial product.